

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

146 Primary Registration District No. 3026 Registrar's No. 24361-012954
STATE FILE NUMBER

AMENDED

Registration District No. 146
FILED MAY 16 1961

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Jackson</u>	b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Independence</u>	a. STATE <u>Missouri</u>	b. COUNTY <u>Jackson</u>
Length of stay in 1b <u>1 day</u>		c. CITY OR TOWN <u>Kansas City</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Indep. Sanitarium</u>		d. STREET ADDRESS (If outside, give location) <u>110 S. Lawn</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First <u>Heilani</u>	Middle <u>F.</u>	Last <u>Stoll</u>	Month <u>May</u>	Day <u>10</u>	Year <u>1961</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5-9-1961</u>	9. AGE (last birthday)	IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	11. BIRTHPLACE (City and state or country) <u>Independence, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Harry F. Stoll</u>	13b. MOTHER'S MAIDEN NAME <u>Theresa Salvador</u>	14. NAME OF HUSBAND OR WIFE <u>Infant</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Harry Stoll</u>	Address <u>K.C. Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART J. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <u>28 hours</u>
IMMEDIATE CAUSE (a)	<u>Cerebral edema</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Anoxia</u>	
	DUE TO (c) <u>Probable hyaline membrane disease</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (but not related to the terminal disease condition given in PART I (a))	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. Month, Day, Year <u> </u>		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u> </u> COUNTY <u> </u> STATE <u> </u>
21. I attended the deceased from <u>7 a.m. (5-9-61)</u> to <u>10:30 a.m. (5-10-61)</u> and last saw her alive on <u>5-10-61</u> <u>10:30 a.m.</u> Death occurred at <u>10:30 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) <u>Quill Walker Jr. M.D.</u>	22b. ADDRESS <u>11200 Wimmer Rd.</u>	22c. DATE SIGNED <u>5-10-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5-10-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet</u>
23d. LOCATION (City, town, or county) <u>Kansas City</u>		(State) <u>Mo.</u>

24. FUNERAL DIRECTOR <u>Roland B. Speaks</u>	ADDRESS <u>Indep. Mo. 5-10-61</u>	25. DATE RECD. BY LOCAL REG. <u>5-10-61</u>	26. REGISTRAR'S SIGNATURE <u>Alba L. Craig, Deputy</u>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Wayne Smith

Licensed Embalmer No. 5081

P. O. Address Indep. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.