

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-032984

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

636 FILED OCT 4 1961

Primary Registration District No. 1002 Registrar's No. 4742

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b life	c. CITY OR TOWN Independence, Missouri
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 6 Grove Street
Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last Kimberly Denise McCain			4. DATE OF DEATH Month Day Year Sept. 23, 1961		
5. SEX Female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6/2/1961	9. AGE (last birthday)	IF UNDER 1 YEAR Months Days Hours Min. 3 21

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (City and state or country) Kansas City, Mo.	12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Dennis McCain		13b. MOTHER'S MAIDEN NAME Dona Faye Moody		14. NAME OF HUSBAND OR WIFE infant

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Address Dennis McCain 6 Grove St. Indep., Mo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH Since birth
IMMEDIATE CAUSE (a) Brain Stem Compression		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Hydrocephalus	
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Myelomeningocele		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 a.m. p.m. Month, Day, Year			
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	COUNTY STATE

21. I attended the deceased from **birth (June '61)** to **23 Sept. 1961** and last saw her alive on **22 Sept 1961**
Death occurred at **4 A.** m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Fred D. Fowler	(Degree or title) M.D.	22b. ADDRESS 4706 Broadway, Kansas City, Mo	22c. DATE SIGNED 23 Sept 1961
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 9/25/61	23c. NAME OF CEMETERY OR CREMATORY Mt. Washington Cemetery	23d. LOCATION (City, town, or county) Independence, Mo.

24. FUNERAL DIRECTOR Earp & Sons	ADDRESS 4707 Truman Rd. K.C., Mo.	25. DATE RECD. BY LOCAL REG. 9-23-61	26. REGISTRAR'S SIGNATURE Ruth Long
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 ITEM NO. SHOULD READ
 BY AFFIDAVIT OF
 MEDICAL CERTIFICATION
 DOCUMENT
 INSTEAD OF

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 James W. Eap

Licensed Embalmer No. 4622
P. O. Address K.C., 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.