

OURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

ENT OF PUBLIC HEALTH AND WELFARE

-61-044748

5998

STATE FILE NUMBER

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

AMENDED

FILED DEC 18 1961

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 Mo.		c. CITY OR TOWN LESS SUMMIT	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Luke's Hospital		d. STREET ADDRESS (If outside, give location) 508 N. GREEN	
3. NAME OF DECEASED (Type or print) First Middle Last INFANT BOY Hatfield		4. DATE OF DEATH Month Day Year NOV 24 1961	
5. SEX MALE	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 11-22-61
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HR. Hours Min. 2 30 3
13a. FATHER'S NAME Norris Lawrence Hatfield		13b. MOTHER'S MAIDEN NAME Edna June Thrasher	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Edna J. Hatfield Address 508 N. GREEN

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Prematurity

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

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.

 Yes No Unknown19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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 NOT WHILE AT WORK

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 11-22-61 to 11-24-61 and last saw her alive on 11-24-61
Death occurred at 12:45 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) William J. Bell M.D. 22b. ADDRESS Peis Summit Mo 22c. DATE SIGNED 11-27-61

23a. BURIAL, CREMATION, REMOVAL (Specify) Hospice Disposal 23b. DATE 11-24-61 23c. NAME OF CEMETERY OR CREMATORY St. Luke's Hospital 23d. LOCATION (City, town, or county) Kansas City, Mo (State)

24. GENERAL DIRECTOR David Gibson M.D. ADDRESS St. Luke's 25. DATE RECD. BY LOCAL REG. 11-29-61 - 26. REGISTRAR'S SIGNATURE Death Form

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF William F. Bell MEDICAL CERTIFICATION

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.

Hospital Disposal

Student _____

Signature of Student Embalmer

Signed *James H. Gibson* _____

Licensed Embalmer No. _____

P. O. Address _____

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.