

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-001730
STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 394

DATE AMENDED
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
John R. Mc Kee

1. PLACE OF DEATH
a. COUNTY JACKSON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY Length of stay in lb 40 MINUTES
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION LAKEVIEW HOSPITAL Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO. b. COUNTY CASS
c. CITY OR TOWN BELTON Inside Limits Yes No
d. STREET ADDRESS (If outside, give location) Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last
Meloney Dee Henrikson
4. DATE OF DEATH Month Day Year
Jan 22 1962

5. SEX FEMALE 6. COLOR OR RACE WHITE 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 1-22-62 9. AGE (last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min. 40

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (City and state or country) Missouri, Kansas U.S.A. 12. CITIZEN OF WHAT COUNTRY

13a. FATHER'S NAME JAMES OLIVER HENRIKSON 13b. MOTHER'S MAIDEN NAME EUNA LUCINE SHANKS. 14. NAME OF HUSBAND OR WIFE NONE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. NONE 17. INFORMANT Hospital Records K.C. Mo. Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage
DUE TO (b) Birth trauma
DUE TO (c) _____
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Crythroblastosis Fetalis
PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

19. 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 1-22-62 to 1-22-62 and last saw her/him alive on 1-22-62
Death occurred at 3:30 p - 1-22-62 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) John R. Mc Kee M.D. 22b. ADDRESS Belton, Mo. 22c. DATE SIGNED 1-23-62

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE 1-24-62 23c. NAME OF CEMETERY OR CREMATORY Belton Cemetery 23d. LOCATION (City, town, or county) (State) Belton Mo.

24. FUNERAL DIRECTOR ADDRESS E.K. George & Sons, Belton, Mo. 25. DATE REGD. BY LOCAL REG. 1-23-62 26. REGISTRAR'S SIGNATURE Ruth Long

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 Jimmy S. Huckabee

Licensed Embalmer No. 4092

P. O. Address Bella, 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.