

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-049684

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6752 STATE FILE NUMBER

FILED FEB 18 1963	
1. PLACE OF DEATH a. COUNTY - <u>JACKSON</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY Mo.</u> Length of stay in 1b <u>8 hrs</u>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Luke's Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>KANSAS</u> b. COUNTY <u>JOHNSON</u>	
c. CITY OR TOWN <u>LENEXA</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS (If outside, give location) <u>9010 Noland Rd</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Infant</u> Middle <u>Girl</u> Last <u>Crawford</u>	
4. DATE OF DEATH Month <u>11</u> Day <u>17</u> Year <u>62</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</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>11-17-62</u>
9. AGE (last birthday) IF UNDER 1 YEAR Months <u>8</u> Days <u>8</u> IF UNDER 24 HR Hours <u>8</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>
11. BIRTHPLACE (City and state or country) <u>KANSAS CITY Mo</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>RAYMOND LELAY CRAWFORD</u>	
13b. MOTHER'S MAIDEN NAME <u>JANET YOXAII</u>	
13c. NAME OF HUSBAND OR WIFE <u>—</u>	
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. <u>—</u>	
17. INFORMANT <u>Raymond Crawford</u> Address <u>Seneca, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fetal Atelectasis</u> DUE TO (b) <u>Prematurity</u> DUE TO (c) <u>—</u> 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)	
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	
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. <u>—</u> 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 COUNTY STATE
21. I attended the deceased from <u>11/17/62</u> to <u>11/17/62</u> and last saw her <u>—</u> alive on <u>11/17/62</u> . Death occurred at <u>3:10</u> <u>p.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>Barley C. Anderson, M.D.</u>	22b. ADDRESS <u>4320 Wornell Road</u>
22c. DATE SIGNED <u>11/17/62</u>	23a. BURIAL OR CREMATION, REMOVAL (Specify) <u>Hospital Disposed</u>
23b. DATE <u>11-17-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Luke's Hosp.</u>
23d. LOCATION (City, town, or county) (State) <u>Kansas City Mo.</u>	24. FUNERAL DIRECTOR <u>David G. Gibson</u> ADDRESS <u>—</u>
25. DATE RECD. BY LOCAL REG. <u>2-13-63</u>	26. REGISTRAR'S SIGNATURE <u>Orith Long</u>

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

BY AFFIDAVIT OF Barley C. Anderson 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 Hospital Disposal, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed David L. Gilman

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.