

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-032215

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1007 Registrar's No. 4380

FILED AUG 20 1963

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSASCITY</u> Length of stay in 1b <u>20 HRS.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>TRINITY LUTHERAN HOSP</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>MISSOURI</u> b. COUNTY <u>CLAY</u> c. CITY OR TOWN <u>Gladstone KANSASCITY 18</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>5807 N. HOWARD</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First Middle Last <u>LAURA ELLEN EGNER</u>			4. DATE OF DEATH Month Day Year <u>8-4-1963</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-3-63</u>	9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR	Months Days Hours Min. <u>20</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		11. BIRTHPLACE (City and state or country) <u>KANSASCITY, MO.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>GROVERA. EGNER</u>		13b. MOTHER'S MAIDEN NAME <u>BONNA RAY MILLER</u>	
14. NAME OF HUSBAND OR WIFE <u>INFANT</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>[REDACTED]</u>	
17. INFORMANT <u>GROVERA. EGNER</u>		Address <u>5807 N. HOWARD K.C. 18. MO</u>			

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ATELECTASIS</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>HYALINE MEMBRANE DISEASE</u> DUE TO (c) <u>POSSIBLE CONGENITAL HEART DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>20 HRS.</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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

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 4:00 PM 8/3/63 to 5 AM 8/4/63 and last saw her/him alive on 8/4/63
 Death occurred at 5:25 AM on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE (Degree or title) Robert J. Gauer M.D. 22b. ADDRESS 2730 So. Mall, K.C. Mo 22c. DATE SIGNED 8-5-63

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE 8-6-1963 23c. NAME OF CEMETERY OR CREMATORY WHITE CHAPEL MEM. GLADSTONE, MO. 23d. LOCATION (City, town, or county) (State)
 24. FUNERAL DIRECTOR D.W. NEWCOMERSONS N.K.C. ADDRESS 8-6-63 25. DATE RECD. BY LOCAL REG. 8-6-63 26. REGISTRAR'S SIGNATURE Ruth Long

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 1
 2 6/30/62
 3
 4 1
 5 0
 6
 7 0
 8 2
 9 754.5
 10
 11
 12 L.P.C.
 13
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 SHOULD READ
 ITEM NO.

DOCUMENT
 MEDICAL CERTIFICATION
 Robert J. Gauer

USE BLACK INK OR TYPEWRITER RIBBON

CLASSIFICATION

CONFIDENTIAL

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 John R. Hennighan

Licensed Embalmer No. 4848

P. O. Address R. 6 1/2 Wm.

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.