

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12615

State File No. 1467

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>1467</u>	
1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. LOUIS</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>KANSAS CITY</u>		c. LENGTH OF STAY (in this place) <u>7 weeks</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SAINT LOUIS (UNIVERSITY CITY)</u>			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>SAINT MARY'S HOSPITAL</u>				d. STREET ADDRESS (If rural, give location) <u>830 PENNSYLVANIA AVENUE</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>MARTHA</u>		b. (Middle) <u>VIRGINIA</u>		c. (Last) <u>PHELAN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>MARCH 31, 1949</u>	
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>5/25/1913</u>	
9. AGE (In years last birthday) <u>35</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>housewife</u>		11. BIRTHPLACE (State or foreign country) <u>KANSAS CITY, MISSOURI</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13a. FATHER'S NAME <u>JOHN L. BRENNAN</u>		13b. MOTHER'S MAIDEN NAME <u>MATTIE HARRIS</u>		14. NAME OF HUSBAND OR WIFE <u>J. E. PHELAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>J. E. Phelan SAINT LOUIS, MO.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Cardiac Failure</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Ovarian Carcinoma</u> DUE TO (c) <u>Generalized Metastasis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Intestinal Obstruction</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>6 YRS.</u> <u>2 YRS.</u> <u>7 Mo.</u>	
19a. DATE OF OPERATION <u>175X</u>		19b. MAJOR FINDINGS OF OPERATION <u>Generalized Ovarian Carcinoma</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>175X</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>175X</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>175X</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>175X</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>175X</u>			
22. I hereby certify that I attended the deceased from <u>6-6</u> , 19 <u>47</u> , to <u>31 MAR 19 49</u> , that I last saw the deceased alive on <u>2 APRIL 19 49</u> , and that death occurred at <u>10 A. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>James W. Downey MD</u>		(Degree or title) <u>MD</u>		23b. ADDRESS <u>800 ARKLE - Bldg. K.C.Mo</u>		23c. DATE SIGNED <u>1 APRIL 49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>4/2/49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Saint Joseph's</u>		24d. LOCATION (City, town, or county) (State) <u>Shawnee, Kansas</u>	
DATE REC'D BY LOCAL REG. <u>4-1-49</u>		REGISTRAR'S SIGNATURE <u>Geraldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Geraldine Holmes</u>		ADDRESS <u>20 West Linwood</u>	

(Licensed Embalmer's Statement on Reverse Side)

6873

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
Student Embalmer

Signed Manda Adair

Licensed Embalmer No. 4016

P. O. Address 20 W. Lenwood

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 this body is not embalmed, fact should be so stated above.