

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **270010**
Registrar's No. **3354**

FILED AUG 21 1950

BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002**

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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, write RURAL and give township) Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Marys Hospital		d. STREET ADDRESS (If rural, give location) 3319 Woodland	
3. NAME OF DECEASED a. (First) Ross (Type or Print)		b. (Middle) H. c. (Last) MONSIL	
4. DATE OF DEATH Aug. 4, 1950		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH June 3, 1888		9. AGE (In years last birthday) 62	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY K.C. Water Dept.	
11. BIRTHPLACE (State or foreign country) Greely Kansas		12. CITIZEN OF WHAT COUNTRY? U S	
13a. FATHER'S NAME William McNeil		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE Mrs. Bonnie McNeil		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 500-20-5077		17. INFORMANT'S SIGNATURE OR NAME Mrs. Bonnie McNeil	
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, asthma, etc. It means the disease, injury, or complication which caused death.		19. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage, Basal ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral arteriosclerosis DUE TO (c) Hypertension II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 331X	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2/7/49 , 19___, to 8-4-50 , 19___, that I last saw the deceased alive on 8/3/50 , 19___, and that death occurred at ___ m., from the causes and on the date stated above.			
23a. SIGNATURE James R. McVay MD (Degree or title)		23b. ADDRESS 814 Porter Bldg	
23c. DATE SIGNED 8/4/50			
24. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8-7-50	
24c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		24d. LOCATION (City, town, or county) (State) Kansas City, Mo.	
DATE REC'D BY LOCAL REG. 8-5-50		REGISTRAR'S SIGNATURE Cheroldine Salmeron	
25. FUNERAL DIRECTOR'S SIGNATURE Mal Pody-McGilley-Eylar		ADDRESS Kansas City, Mo.	

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Glen E. Heck

Signed.....
Student Embalmer

Licensed Embalmer No. 4063

P. O. Address Kansas City, 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 this body is not embalmed, fact should be so stated above.