

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
590

FILED MAR 3 1951

No. 300
10-48

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

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>Jackson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>	
c. LENGTH OF STAY (In this place) <u>48 yrs.</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Mary's Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>5836 Harrison</u>	

3870

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) <u>Mary</u>	b. (Middle) <u>Frances</u>	c. (Last) <u>O'HARE</u>	(Month) <u>Feb.</u>	(Day) <u>5</u>	(Year) <u>1951</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>8-5-95</u>	9. AGE (In years last birthday) <u>55</u>	IF UNDER 1 YEAR: Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Boston, Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>

13a. FATHER'S NAME <u>John Normile</u>	13b. MOTHER'S MAIDEN NAME <u>Johanna Sullivan</u>	14. NAME OF HUSBAND OR WIFE <u>Dennis O'Hare</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Dennis O'Hare</u>	ADDRESS <u>5836 Harrison, K. C., Mo.</u>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>10 mos.</u> <u>5810</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Biliary cirrhosis</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION <u>Biliary cirrhosis</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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 type="checkbox"/>	21h. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from Jan 25, 1951, to Feb 4, 1951, that I last saw the deceased alive on Feb 4, 1951, and that death occurred at _____ m., from the causes and on the date stated above.

22a. SIGNATURE <u>L. P. Engel</u>	(Degree or title) <u>Med.</u>	22b. ADDRESS <u>Plaza Med Bldg</u>	22c. DATE SIGNED <u>2-7-51</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>2-7-51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet</u>	24d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>2-8-51</u>	REGISTRAR'S SIGNATURE <u>Geraldine Holmes</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Melody-McGillie-Eylar</u>	ADDRESS <u>Kansas City, Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

name of deceased
date of death
place of death
cause of death
sex
age
color
height
weight
hair
eyes
complexion
occupation
education
religion
marital status
social status
other pertinent information

For embalming
Room 800 -
Please Medical Body
Leaves for Doctor -
Please call for information
No. 11111

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 _____

Glen E. Beck

Licensed Embalmer No. 4063

P. O. Address E. E. Ave.

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.