

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

State File No. **20601**

No. 900
10-48

FILED JUL 5 1952

BIRTH NO. _____ REG. DIST. NO. 199 PRIMARY REG. DIST. NO. 1000 Registrar's No. 2644

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) | |
| a. COUNTY Jackson | | a. STATE MISSOURI b. COUNTY JACKSON | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City, Mo. | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN KANSAS CITY | |
| c. LENGTH OF STAY (In this place) 10 YRS. | | d. STREET ADDRESS (If rural, give location) St. Joseph Hospital | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Joseph | | | |

| | | | | | | | |
|---|-----------------------------|-------------|-------------------------|-------------------------|-------------------|-----------------|------------------|
| 3. NAME OF DECEASED (Type or Print) | a. (First) Mary Pius | b. (Middle) | c. (Last) Neenan | 4. DATE OF DEATH | (Month) 6/ | (Day) 10 | (Year) 52 |
|---|-----------------------------|-------------|-------------------------|-------------------------|-------------------|-----------------|------------------|

| | | | | | | | | |
|---------------------------|-------------------------------------|--|--|--|---------------------------------|-------------------------------|--------------------------------|-------------------------------|
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) NEVER MARRIED | 8. DATE OF BIRTH 10/15/75 | 9. AGE (In years last birthday) 86 7/8 | # UNDER 1 YEAR Months | # UNDER 1 YEAR Days | # UNDER 1 YEAR Hours | # UNDER 1 YEAR Min. |
|---------------------------|-------------------------------------|--|--|--|---------------------------------|-------------------------------|--------------------------------|-------------------------------|

| | | | |
|--|---|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Religious | 10b. KIND OF BUSINESS OR INDUSTRY St. Joseph Hosp. | 11. BIRTHPLACE (State or foreign country) IOWA | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
|--|---|---|--|

| | | |
|--|---|---|
| 13a. FATHER'S NAME James Neenan | 13b. MOTHER'S MAIDEN NAME Margaret Leahy | 14. NAME OF HUSBAND OR WIFE NONE |
|--|---|---|

| | | | |
|--|--|--|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | 16. SOCIAL SECURITY NO. NONE | 17. INFORMANT'S SIGNATURE OR NAME Sister Michaela Marie | ADDRESS St. Joseph Hosp. K.C. Mo. |
|--|--|--|--|

| | | | |
|--|--|--|--|
| 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. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH 33 1/2 |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Encephalomalacia | | |
| | ANTECEDENT CAUSES DUE TO (b) Cerebral Arteriosclerosis <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (c) | | |
| II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i> | | | |

| | | |
|-------------------------------|---|--|
| 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) (Min.) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
|---|--|-----------------------------------|

22. I hereby certify that I attended the deceased from _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

| | | |
|--|---|--|
| 23a. SIGNATURE Russell W. Karr MD | 23b. ADDRESS St. Joseph Hospital | 23c. DATE SIGNED 11/21/52 |
|--|---|--|

| | | | |
|--|------------------------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL | 24b. DATE 6-11-52 | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) ST. LOUIS MO. |
|--|------------------------------------|---|--|

| | | | |
|---|---|--|-----------------------------------|
| DATE REC'D BY LOCAL REG. 6-11-52 | REGISTRAR'S SIGNATURE Geraldine Holmes | 25. FUNERAL DIRECTOR'S SIGNATURE Melody-McGILLEY-EYAR | ADDRESS K.C. MO. |
|---|---|--|-----------------------------------|

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

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 *Adrian Jay Stitt*

Licensed Embalmer No. *4882*

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.