

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

17920

State File No. ....

FILED MAY 27 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 2392

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas city</u>		c. LENGTH OF STAY (In this place) <u>1 year</u>	c. CITY OR TOWN <u>Kansas city</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St Joseph Hospital</u>		STREET ADDRESS (If rural, give location) <u>1419 E 8th St</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>JOHN</u>	b. (Middle) <u>M</u>	c. (Last) <u>BROPHY</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>5-9-1953</u>
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5. SEX <u>M</u>	6. COLOR OR RACE <u>wh.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>3-1-1879</u>	9. AGE (In years last birthday) <u>74</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 4 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Salesman</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) <u>Kingston N.Y.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Michael Brophy</u>	13b. MOTHER'S MAIDEN NAME <u>Ann Delaney</u>	14. NAME OF HUSBAND OR WIFE <u>Katherine Brophy</u>
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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>514-09-0795</u>	17. INFORMANT'S SIGNATURE OR NAME <u>John J. Brophy</u>	ADDRESS <u>KE 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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Encephalomyelasia of Pons</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cerebral atherosclerosis years</u>		
	DUE TO (c) <u>Generalized arteriosclerosis years</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			<u>332 X</u>

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from 4-18-1947 to 5-9-1953 that I last saw the deceased alive on 5-8-1953 and that death occurred at 12:45 am., from the causes and on the date stated above.

23a. SIGNATURE THOS. G. Mc Hale (Degree or title) <u>Thos. G. Mc Hale MD</u>	23b. ADDRESS <u>4620 S. Indiana Ave</u>	23c. DATE SIGNED <u>5-9-53</u>
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24a. PORTAL CREMATION REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>5-11-1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cem Jackson Kans</u>	24d. LOCATION (City, town, or county) (State) _____
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DATE REC'D BY LOCAL REG <u>5-9-53</u>	REGISTRAR'S SIGNATURE <u>Geraldine Smith</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Gasparino Bros</u>	ADDRESS <u>KE MO</u>
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

DW McHale or Dr Schuman  
ch 5750  
11820 Jondrop care

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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. Schuman*

Licensed Embalmer No. *4531*

P. O. Address *Ke 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.