

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28744

State File No.

FILED SEP 11 1953

4160

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		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>Mo.</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, write RURAL and give town OR TOWN <u>Kansas City</u>)		c. LENGTH OF STAY (In this place) <u>50 years</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Little Sisters of the Poor</u>				d. STREET ADDRESS (If rural, give location) <u>5331 Highland Ave. 37580</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Anthony</u>		b. (Middle) <u>Joseph</u>		c. (Last) <u>McNellis</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 22, 1953</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Dec. 6, 1882</u>	
9. AGE (In years last birthday) <u>70</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 11 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Caretaker (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>K.C. Mo. Water Dept.</u>		11. BIRTHPLACE (State or foreign country) <u>Dept. County Donegan, Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James McNellis</u>		13b. MOTHER'S MAIDEN NAME <u>Ann Heekan</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs Hannah McNellis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs Hannah McNellis 5331 Highland</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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Broncho pneumonia</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic Nephritis</u> DUE TO (c) <u>Arterio sclerosis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Fracture of left hip</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 mos.</u> <u>4 days</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Fracture of Surgical Neck of L. Femur.</u>				20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
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 <u>8/19 1953</u> to <u>8/22/53</u> , 19____, that I last saw the deceased alive on <u>8/22</u> , 19 <u>53</u> , and that death occurred at <u>5:40 P.M.</u> from the causes and on the date stated above.							
23a. SIGNATURE <u>Joseph A. Fogarty</u> DO <u>MC</u>				23b. ADDRESS <u>402 Northman Rte 137 No</u>		23c. DATE SIGNED <u>8/24/53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Aug. 25, 1953</u>		24c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>K.C. Mo.</u>	
DATE REC'D BY LOCAL REG. <u>8-24-53</u>		REGISTRAR'S SIGNATURE <u>Geraldine Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Thos. E. Quirk 4316 Troost Ave.</u>			

(Licensed Embalmer's Statement on Reverse Side)

WHILE 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.....

.....
working under my personal supervision.

Student
Student Embalmer

Signed *Thomas D. De...*
Student Embalmer No. *3175*

Licensed Embalmer No. *R.O. 7*

P. O. Address.....

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.