

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

8795

State File No. \_\_\_\_\_

BIRTH NO. FILED MAR 25 1954 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 1080

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY Jackson  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE Missouri b. COUNTY Jackson |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN Kansas City | c. LENGTH OF STAY (in this place)<br>70 yrs. | c. CITY OR TOWN Kansas City   | d. Is Residence within limits of a city or incorporated town?<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION: General Hospital No. 1                             |  | e. STREET ADDRESS (If rural, give location)<br>2740 Summit  |  |

|   |  |             |                     |   |  |  |
|---|--|-------------|---------------------|---|--|--|
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) Clara |  | b. (Middle) | c. (Last) McDonnell | 4. DATE OF DEATH (Month) (Day) (Year)<br>3 8 1954 |  |  |
|---|--|-------------|---------------------|---|--|--|

|               |                        |  |                               |   |                        |                       |       |      |
|---------------|------------------------|--|-------------------------------|---|------------------------|-----------------------|-------|------|
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Married | 8. DATE OF BIRTH July 8-18 76 | 9. AGE (in years) (Month) (Day) (Year) 77 | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | Hours | Min. |
|---------------|------------------------|--|-------------------------------|---|------------------------|-----------------------|-------|------|

|  |  |  |                                       |
|--|--|--|---------------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife | 10b. KIND OF BUSINESS OR INDUSTRY<br>At Home | 11. BIRTHPLACE (City and State or Foreign Country)<br>Mt. Sterling, Illinois | 12. CITIZEN OF WHAT COUNTRY<br>U.S.A. |
|--|--|--|---------------------------------------|

|                                     |   |   |
|-------------------------------------|---|---|
| 13a. FATHER'S NAME<br>William Algie | 13b. MOTHER'S MAIDEN NAME<br>Mary M. Schott | 14. NAME OF HUSBAND OR WIFE<br>Alexander J. McDonnell |
|-------------------------------------|---|---|

|   |                                 |   |                        |
|---|---------------------------------|---|------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)<br>No | 16. SOCIAL SECURITY NO.<br>None | 17. INFORMANT'S SIGNATURE OR NAME<br>Alexander J. McDonnell | ADDRESS<br>2740 Summit |
|---|---------------------------------|---|------------------------|

|   |  |  |  |
|---|--|--|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac hypertrophy and dilatation<br><br>ANTECEDENT CAUSES<br>DUE TO (b) Mitral ring calcification with stenosis<br>DUE TO (c) with stenosis<br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  | INTERVAL BETWEEN ONSET AND DEATH<br><br>410X |
|---|--|--|--|

|                        |                                  |   |
|------------------------|----------------------------------|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY?<br>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) | 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 March 1, 1954, to March 8, 1954, that I last saw the deceased alive on March 8, 1954, and that death occurred at 8:15 A. M., from the causes and on the date stated above.

|  |                               |                            |
|--|-------------------------------|----------------------------|
| 23a. SIGNATURE<br>B.I. Burns (Degree or title)<br>B.I. Burns, M.D. | 23b. ADDRESS<br>24th & Cherry | 23c. DATE SIGNED<br>3-8-54 |
|--|-------------------------------|----------------------------|

|  |                            |  |   |
|--|----------------------------|--|---|
| 24a. BURIAL OR CREMATION (Specify)<br>Burial | 24b. DATE<br>March 10 1954 | 24c. NAME OF CEMETERY OR CREMATORY<br>Mt. Calvary Cemetery | 24d. LOCATION (City, town, or county) (State)<br>Kansas City Kansas |
|--|----------------------------|--|---|

|                                     |  |   |                                      |
|-------------------------------------|--|---|--------------------------------------|
| DATE REC'D BY LOCAL REG.<br>3-10-54 | REGISTRAR'S SIGNATURE<br>Seraldine Smith | 25. FUNERAL DIRECTOR'S SIGNATURE<br>The Regent Funeral Home | ADDRESS<br>1900 Central St. C. Kans. |
|-------------------------------------|--|---|--------------------------------------|

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

*Dr King*

*[Faint stamp]*

*6619 208*

**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 *Robert Emmet Nugent*

Licensed Embalmer No. *2491*

P. O. Address *1900 Central*

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.