

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

2044

FILED MAY 28 1954

0.300  
0.48

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1009</u>		Registrar's No. <u>2044</u>			
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) <u>Kansas City</u>		c. LENGTH OF STAY (in this place) township) <u>67 years</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Kansas City</u>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>15 West 73rd Terr.</u>				d. STREET ADDRESS (If rural, give location) <u>15 West 73rd Terr.</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Matthew</u>		b. (Middle) <u>Joseph</u>		c. (Last) <u>McNamara</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 5, 1954</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>Sept. 9, 1874</u>	9. AGE (In years last birthday) <u>79 years</u>	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) <u>retired watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>K.C. Mo. Park Dept.</u>		11. BIRTHPLACE (State or foreign country) <u>Clare, Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13a. FATHER'S NAME <u>No record</u>		13b. MOTHER'S MAIDEN NAME <u>Nor record</u>		14. NAME OF HUSBAND OR WIFE <u>Katie McNamara</u>					
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>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs Edward L. Healy 15 West 73rd Terr</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>Neurotic Depression</u> ANTECEDENT CAUSES DUE TO (b) <u>arteriosclerosis</u> Morbidity conditions, if any, giving rise to the above cause, (a) stating the underlying cause last: DUE TO (c) <u>senility</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>  <u>45</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input 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) m.		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>March</u> , 1954, to <u>May 5</u> , 1954, that I last saw the deceased alive on <u>May 4</u> , 1954, and that death occurred at <u>4:30 P.M.</u> the causes and on the date stated above.									
23a. SIGNATURE <u>H.F. Grams</u> (Degree or title) <u>H.F. Grams</u>				23b. ADDRESS <u>1102 E 47th St. K.C. Mo.</u>		23c. DATE SIGNED <u>May 5, 1954</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>May 7, 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		24d. LOCATION (City, town, or county) (State) <u>K.C. Mo.</u>			
DATE REC'D BY LOCAL REG. <u>5-6-54</u>		REGISTRAR'S SIGNATURE <u>Sheraldine Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Thos. E. Quirk 4316 Troost Ave.</u>					

WRITE PLAINLY—USING UNFAADING 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

.....  
Student Embalmer No. ....  
*Ronald Lewis*  
Licensed Embalmer No. 3775  
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.