

FILED JUN 3 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **16029**
2219

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|---|-------------------------------|--|---|--|--|--|----------------------------|
| BIRTH NO. | | REG. DIST. NO. <u>149</u> | | PRIMARY REG. DIST. NO. <u>1002</u> | | Registrar's No. <u>2219</u> | |
| 1. PLACE OF DEATH a. COUNTY Jackson | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson | | | |
| b. CITY OR TOWN Kansas City | | c. LENGTH OF STAY (In this place) 58 yrs. | | c. CITY OR TOWN Kansas City | | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Hospital | | | | e. STREET ADDRESS (If rural, give location) 3719 Valentine Road 3468 | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) John | | b. (Middle) F. | | c. (Last) MAHER | | 4. DATE OF DEATH (Month) (Day) (Year) May 16, 1954 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married | 8. DATE OF BIRTH 7-25-69 | 9. AGE (In years last birthday) 84 | IF UNDER 1 YEAR Months | IF UNDER 1 YEAR Days | IF UNDER 1 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and State or Foreign Country) Oil City, Pa. / | | 12. CITIZENRY OF WHAT COUNTRY? USA | |
| 13a. FATHER'S NAME Michael Maher | | | 13b. MOTHER'S MAIDEN NAME Ellen -- | | 14. NAME OF HUSBAND OR WIFE none | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 497-14-2194 | | 17. INFORMANT'S SIGNATURE OR NAME George E. Tierney ADDRESS 3719 Valentine Rd., KC, 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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Arterio Sclerosis DUE TO (c) General Arterio Sclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Bronchitis | | | | INTERVAL BETWEEN ONSET AND DEATH 2 days 5 yrs 5 yrs 10 yrs | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION 331X | | | | 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) (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>5/12</u> , 19 <u>54</u> , to <u>5/16</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>5/15</u> , 19 <u>54</u> , and that death occurred at _____ m., from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE P. J. O'Connell (Degree or title) M.D. | | | | 22b. ADDRESS 327 Ashby Bldg K.C.Mo | | 22c. DATE SIGNED 5/17/54 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 24b. DATE 5-18-54 | 24c. NAME OF CEMETERY OR CREMATORY Mount Calvary | | 24d. LOCATION (City, town, or county) (State) Kansas City, Kansas | | |
| DATE REC'D BY LOCAL REG. 5-17-54 | | REGISTRAR'S SIGNATURE Seraldine Smith | | 25. FUNERAL DIRECTOR'S SIGNATURE Melody-McGilley-Eylar ADDRESS Kansas City, Mo. | | | |

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

Dr. P. J. O'Connell
Argyle Bldg

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 *James Hackleman*

Licensed Embalmer No. *45*

P. O. Address *K.E.M.*

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.