

FILED OCT 19 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **33390**

4156

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).			
a. COUNTY Jackson		b. CITY OR TOWN Kansas City		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"/>	
c. LENGTH OF STAY (in this place) Life		e. STREET ADDRESS 90		f. (If rural, give location) 7205 Wabash		g. COUNTY Jackson	
d. FULL NAME OF HOSPITAL OR INSTITUTION Osteopathic Hospital				3. NAME OF DECEASED			
a. (First) DENNIS		b. (Middle) P.		c. (Last) MC GLYNN		4. DATE OF DEATH (Month) (Day) (Year) 9 - 23 - 55	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH April 1, 1952	
9. AGE (In years last birthday) 3		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY -----		9. AGE (In years last birthday) 3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (City and State or Foreign Country) Kansas City, Mo.		12. CITIZEN OF WHAT COUNTRY? US.A.	
13a. FATHER'S NAME Robert J. McGlynn		13b. MOTHER'S MAIDEN NAME Geneva Stucker		14. NAME OF HUSBAND OR WIFE -----			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT'S SIGNATURE OR NAME Robert J. McGlynn		ADDRESS 7205 Wabash	
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c)				MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute pneumonia				DUE TO (b) Acute lymphatic Leukemia		7 months	
*This does not mean the mode of dying, such as heart failure, assthenia, etc. It means the disease, injury, or complication which caused death.				DUE TO (c) -----		1040	
II. OTHER SIGNIFICANT CONDITIONS Paralytic ileus				DUE TO (b) -----		1 day	
Conditions contributing to the death but not related to the disease or condition causing death.				DUE TO (c) -----		-----	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? 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) 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>Apr. 4, 1955</u> to <u>Sep. 23, 1955</u> , that I last saw the deceased alive on <u>Sep. 23, 1955</u> and that death occurred at <u>2:20 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE Myron D Jones (Degree or title) DD				23b. ADDRESS 926 E. 11th		23c. DATE SIGNED 9/25/55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 9-26-55		24c. NAME OF CEMETERY OR CREMATORY Floral Hills Cemetery		24d. LOCATION (City, town, or county) (State) Hickman Mills, Mo.	
DATE REC'D BY LOCAL REG. 9-25-55		REGISTRAR'S SIGNATURE neva minshall		25. FUNERAL DIRECTOR'S SIGNATURE Melody-McGilley-Eylar		ADDRESS Kansas City, Mo.	

(Licensed Embalmer's Statement on Reverse Side)

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

Mr. Jones - D.O.
Di. Jones - D.O.
Dr. Jones - D.O.
6224
all afternoon Sun.
Project
James

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... *Arthur E. Hoak*

Licensed Embalmer No. *49*

P. O. Address *19 C 2*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.