

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33421

State File No. ....

FILED OCT 19 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 4214

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>KANSAS CITY MISSOURI</u>		c. CITY OR TOWN <u>KANSAS CITY</u>	
c. LENGTH OF STAY (In this place) <u>30 YEARS</u>		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 <u>MENORAH MEDICAL CENTER</u>		STREET ADDRESS (If rural, give location) <u>4333 BELLE FONTAINE AVENUE</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>VADA</u>	b. (Middle) <u>L.</u>	c. (Last) <u>MOONEY</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>SEPTEMBER 28 1955</u>
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>DEC-25-1893</u>	9. AGE (In years last birthday) <u>61</u>	IF UNDER 1 YEAR: Months _____ Days _____	IF UNDER 24 HRS: Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>- - - -</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>KANSAS CITY KANSAS</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>HENRY N. SAVAGE</u>	13b. MOTHER'S MAIDEN NAME <u>LANA GENTLE</u>	14. NAME OF HUSBAND OR WIFE <u>CLARENCE R. MOONEY</u>
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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>488-38-7961</u>	17. INFORMANT'S SIGNATURE OR NAME <u>CLARENCE R. MOONEY</u>	ADDRESS <u>4333 BELLE FONTAINE KANSAS CITY, MO.</u>
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Malignant glioma - spongioblastoma multiforme - Rt. Left frontal lobe - brain</u>		INTERVAL BETWEEN ONSET AND DEATH  <u>2 mos.</u>  <u>193h</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION <u>9/27/55</u>	19b. MAJOR FINDINGS OF OPERATION <u>Malignant Brain tumor left frontal lobe</u>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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 9/23/1955 to 9/28/1955, that I last saw the deceased alive on 9/28/1955 and that death occurred at 12:10 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>William Q. Wa</u> (Degree or title) <u>M.D.</u>	23b. ADDRESS <u>701 E. 63rd St. K.C. Mo</u>	23c. DATE SIGNED <u>9/28/55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	24b. DATE <u>SEPT. 30 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>D.W. NEW COMERS SONS</u>	24d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>
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DATE REC'D BY LOCAL REG. <u>9-30-55</u>	REGISTRAR'S SIGNATURE <u>vera minshall</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>D.W. Newcomer Sons</u>	ADDRESS <u>1331 BRUSH CREEK KANSAS CITY, MO.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

*Spongioblast*

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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 *Rollie Kessel*.....

Licensed Embalmer No. *469*

P. O. Address *K.C.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.