

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED APR 11 1956

BIRTH NO.		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>1259</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 (If outside corporate limits, write RURAL and give town(ship)) OR TOWN Kansas City		c. LENGTH OF STAY (In this place) 66 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. Luke's Hospital				STREET ADDRESS (If rural, give location) 814 117 West 58 Terr. 38480			
3. NAME OF DECEASED (Type or Print) a. (First) EVA		b. (Middle) MAY		c. (Last) DAY		4. DATE OF DEATH (Month) (Day) (Year) March 20, 1956	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH July 24, 1873		9. AGE (In years last birthday) 82	IF UNDER 1 YEAR Months Days Hours Mins.	IF UNDER 1 YRS. Hours Mins.
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) Olathe, Kansas		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME James Wells		13b. MOTHER'S MAIDEN NAME Frances McIntyre		14. NAME OF HUSBAND OR WIFE Charles B. Day			
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. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Miss Emma Day, 117 W. 58 Terr., K.C. 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) acute Cerebro Vascular Occlusion ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) gen. atherosclerosis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. angina pectoris				INTERVAL BETWEEN ONSET AND DEATH 5 days 332X	
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>Jan 2, 1952</u> , to <u>Mar. 20, 1956</u> , that I last saw the deceased alive on <u>Mar 20, 1956</u> , and that death occurred at <u>3:30 p. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Raymond W. O'Brien M.D.				23b. ADDRESS 231 W 47 K.C. Mo		23c. DATE SIGNED 3-22-56	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE 3/23/56	24c. NAME OF CEMETERY OR CREMATORY Mt. Moriah		24d. LOCATION (City, town, or county) (State) Kansas City, Missouri		
DATE REC'D BY LOCAL REG. 3-22-56		REGISTRAR'S SIGNATURE newe minshall		25. FUNERAL DIRECTOR'S SIGNATURE STINE & McCLURE UND. CO.		ADDRESS K.C.MO.	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNEADING BLACK INK—MAKE A PERMANENT RECORD
Raymond B. O'Brien

A. J. Raymond O'Brien
195 Plaza Time Bldg.
Je 1-1225

Epp 3:20

St Luke's Emery Room
10:00 a.m. Friday

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 M. [Signature]

Licensed Embalmer No.....

P. O. Address.....
K 69

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.