

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

26826

State File No. ....

FILED AUG 29 1956

S. No. 300  
V. 10.48

BIRTH NO. .... REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 2280

1. PLACE OF DEATH  
a. COUNTY Jackson 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
a. STATE Mo. b. COUNTY Jackson

b. CITY (If outside corporate limits, write RURAL and give township) Kansas City c. LENGTH OF STAY (in this place) 14 years  
c. CITY OR TOWN Kansas City d. In Residence within limits of a city or incorporated town? Yes  No

d. FULL NAME OF HOSPITAL OR INSTITUTION Little Sisters Home e. STREET ADDRESS (If rural, give location) 5331 Highland Ave.  
75 37580

3. NAME OF DECEASED a. (First) William b. (Middle) Connolly c. (Last) Connolly 4. DATE OF DEATH (Month) (Day) (Year) Aug. 3, 1956

5. SEX Male 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 8. DATE OF BIRTH April 3, 1975 9. AGE (In years last birthday) Months Days 81 years

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer 10b. KIND OF BUSINESS OR INDUSTRY ----- 11. BIRTHPLACE (City and State or Foreign Country) Ireland 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME No record 13b. MOTHER'S MAIDEN NAME No record 14. NAME OF HUSBAND OR WIFE No record

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. No 17. INFORMANT'S SIGNATURE OR NAME Mother Superior, Little Sisters ADDRESS Home

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, asphyxia, etc. It means the disease, injury, or complication which caused death.  
MEDICAL CERTIFICATION  
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) Cerebral Hemorrhage INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs  
ANTECEDENT CAUSES Arterio sclerosis DUE TO (b) 20 yrs  
DUE TO (c) -----  
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 331X

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES  NO

21a. ACCIDENT (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  NOT WHILE AT WORK  21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/19, 1955, to 8/3, 1956, that I last saw the deceased alive on 8/1, 1956, and that death occurred at 6.45 AM the causes and on the date stated above.

23a. SIGNATURE Joseph A. Fogarty (Degree or title) 23b. ADDRESS 25811 Truman Rd K.C. 26 Mo 23c. DATE SIGNED 8/4/56

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE Aug. 4, 1956 24c. NAME OF CEMETERY OR CREMATORY Mt. Olivet 24d. LOCATION (City, town, or county) (State) Hickman Mills, Mo.

DATE REC'D BY LOCAL REG. 8-4-56 REGISTRAR'S SIGNATURE New Marshall 25. FUNERAL DIRECTOR'S SIGNATURE Thos. E. Quirk ADDRESS 4316 Troost K.C. Mo.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING 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 ..... Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Howard J. [Signature]*  
Licensed Embalmer No. *2137*  
P. O. Address *[Signature]*

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.