

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34121

State File No. 4287

BIRTH NO. 70292-56 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY. Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO. COUNTY JACKSON	
b. CITY (If outside corporate limits, write RURAL and give township) Kan. City Mo.		c. CITY OR TOWN Kan. 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 Hospital		e. STREET ADDRESS (If rural, give location) 2490 26 E LINWOOD	

3. NAME OF DECEASED (Type or Print) KATHLEEN ANN MEEHAN	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) 10 1 56
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5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) INFANT	8. DATE OF BIRTH 9-28-56	9. AGE (In years last birthday) 4	IF UNDER 1 YEAR Months 4	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) INFANT	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Kan. City Mo.	12. CITIZEN OF WHAT COUNTRY? US.
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13a. FATHER'S NAME DALE ALLEN MEEHAN	13b. MOTHER'S MAIDEN NAME ELIZABETH JEAN ZAHNER	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Geo W Weid MD	ADDRESS K.C. MO.
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) PNEUMONIA		INTERVAL BETWEEN ONSET AND DEATH 72 hr
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) ATELECTASIS		
	DUE TO (c) SEPSIS OF NEWBORN		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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) Kan. Jackson MO.
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 **9-28, 1956**, to **1 Oct, 1956**, that I last saw the deceased alive on **1 Oct, 1956**, and that death occurred at **4:30 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE Geo W Weid	(Degree or title) MD.	23b. ADDRESS 2150 Parkway Blvd KC Mo	23c. DATE SIGNED 2 Oct 56
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24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE 10-2-56	24c. NAME OF CEMETERY OR CREMATORY Resurrection	24d. LOCATION (City, town, or county) (State) LENEXA KANSAS
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DATE REC'D BY LOCAL REG. 10-2-56	REGISTRAR'S SIGNATURE Merna Marshall	25. FUNERAL DIRECTOR'S SIGNATURE Rayce Gage	ADDRESS Overland Park KS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
Geo. W. Wise, M.D.

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.....

Licensed Embalmer No.....

P. O. Address

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.