

Diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 2 - 1956

34288

STATE FILE NUMBER

4482

Registration District No. 149 Primary Registration District No. 1.002 Registrar's No. 4482

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, give TOWNSHIP only) OR TOWN <u>Kansas City, Missouri</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>66</u> <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Menorah Medical Center</u>			Length of stay in lb <u>40 yrs</u>		d. STREET ADDRESS <u>412 E. 64th Terr.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Tierney</u> Last <u>Tierney</u>				4. DATE OF DEATH Month <u>October</u> Day <u>14</u> Year <u>1956</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 8 - 1904</u>		9. AGE (In years last birthday) <u>52 yrs</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner & operator</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Tierney Refrigerator</u>		11. BIRTHPLACE (City and state or country) <u>Leavenworth Kansas</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>George Tierney</u>				14. MOTHER'S MAIDEN NAME <u>Annice Rooney</u>									
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>486-01-9762</u>		17. INFORMANT <u>Mrs Regina Tierney</u> Address <u>412 E 64th Terr</u>								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diffuse pulmonary hemorrhage.</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Internal Carotid Artery Thrombosis.</u> <u>72 hours</u> DUE TO (c) <u>Cardio-vascular hypertensive (Renal)</u> <u>2 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>442x</u>													
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Hour <u> </u> Month <u> </u> Day <u> </u> Year <u> </u> a. m. <u> </u> p. m. <u> </u>													
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE					
21. I attended the deceased from <u>10/13/56</u> to <u>10/14/56</u> and last saw <u>him</u> alive on <u>10/14/56</u> Death occurred at <u> </u> m on the date stated above; and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>Paul Moss</u> (Degree or title) <u>D</u>				22b. ADDRESS <u>406 Bryant Bldg.</u>			22c. DATE SIGNED <u>10/15/56</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10/17/56</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City Mo</u>							
24. FUNERAL DIRECTOR <u>Melody McElly</u> ADDRESS <u> </u>			25. DATE RECD. BY LOCAL REG. <u>10-15-56</u>		26. REGISTRAR'S SIGNATURE <u>Reva Marshall</u>								

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....*James W. Wair*.....

Licensed Embalmer No.....*4*.....

P. O. Address.....*Kan. C.*.....

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