

Health, Welfare, Public Service

300 1-56

doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Carl H. Brust

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4898

STATE FILE NUMBER

619

FILED MAR 4 1957

Registration District No. 149 Primary Registration District 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 Missouri b. COUNTY Jackson | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Kansas City | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1424 West 50th Terr | | Length of stay in lb 50 yrs. | d. STREET ADDRESS 1424 West 50th Terr. | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First ELLEN Middle AGNES Last O'BRIEN | | | 4. DATE OF DEATH Month Day Year Feb. 5, 1957 | | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 19, 1893 | 9. AGE (In years last birthday) 64 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Grocery Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY Retail Grocery | 11. BIRTHPLACE (City and state or country) Atchison, Kansas | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Michael Collins | | | 14. MOTHER'S MAIDEN NAME Delia Cotter | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yrs. give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 492-18-2524 | 17. INFORMANT Address Mrs. Edwin Nelson-1424 West 50th Terr. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia, Bilateral DUE TO (b) Arterio-sclerotic changes of foot DUE TO (c) Generalized Arterio-sclerosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 days 4 wks 5 yrs 4501 |
| 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 Month, Day, Year a. m. p. m. | | | | | |
| 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 Dec-15-56 to Jan-5-57 and last saw her alive on Jan-5-57. Death occurred at 7 m on the date stated above; and to the best of my knowledge from the causes stated. | | | | | |
| 22a. SIGNATURE Carl H. Brust M.D. (Degree or title) | | 22b. ADDRESS 106 W 14th St - KC Mo | 22c. DATE SIGNED Jan 7 57 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 2/8/57 | 23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery | 23d. LOCATION (City, town, or county) (State) Kansas City, Missouri | | |
| 24. FUNERAL DIRECTOR ADDRESS QUIRK & TOBIN-20 W. Linwood, K.C.Mo. | | 25. DATE RECD. BY LOCAL REG. 2-8-57 | 26. REGISTRAR'S SIGNATURE neva minshall | | |

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 *William M. Turner*

Licensed Embalmer No. *467*

P. O. Address *20 W. Lincoln*

Kansas City

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (1)
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.