

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

13268  
STATE FILE NUMBER  
1540  
REGISTRAR'S NO.

FILED APR 16 1957

Registration District No. 149 Primary Registration District No. 1002

Health,  
Welfare  
Public  
Services

300  
1-56

Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. All symptoms will be listed. No symptoms will be listed. All

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
E. Robert Nigro

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Downtown Hosp. 48 hrs Life</b> Length of stay, in 1b		d. STREET ADDRESS <b>208 West Linwood Blvd.</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Patrick</b> Last <b>McShane</b>			4. DATE OF DEATH Month <b>April</b> Day <b>1</b> Year <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 10, 1896</b>
9. AGE (In years last birthday) <b>60 years</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired ticket Agent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Burlington R.R.</b>	11. BIRTHPLACE (City and state or country) <b>Kansas City Mo.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Michael McShane</b>	
14. MOTHER'S MAIDEN NAME <b>Celia Sweeney</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes World War 1</b>	
16. SOCIAL SECURITY NO. <b>707-09-2323</b>		17. INFORMANT <b>Mrs Catherine P. McShane 208 W Linwood</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO (b) <b>Atherosclerotic Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cirrhosis of Liver</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5-10 Minutes</b> <b>42<sup>nd</sup></b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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 <b>3/5/52</b> to <b>4-1-57</b> and last saw <sup>her</sup> <sub>him</sub> alive on <b>4-1-57</b> Death occurred at <b>11:30 A.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>S Robert Nigro MD</b> (Degree or title)		22b. ADDRESS <b>1222 McSher</b>	22c. DATE SIGNED <b>4-1-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>April 4, 1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>	23d. LOCATION (City, town, or county) (State) <b>Hickman Mills, Mo.</b>
24. FUNERAL DIRECTOR <b>Thos, E. Quirk Funer al Home 4316 Trodst Ave.</b>		25. DATE RECD. BY LOCAL REG. <b>4-2-57</b>	26. REGISTRAR'S SIGNATURE <b>new Minshall</b>

KP  
2

**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 *Thomas B. [Signature]*

Licensed Embalmer No. ....

P. O. Address .....

**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.**