

Health, Welfare & Public Service

300  
1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

Hugh H. O'NEALS  
MEDICAL CERTIFICATION  
ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED MAY 1 - 1957

STANDARD CERTIFICATE OF DEATH

13367

STATE FILE NUMBER 1703

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1703

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		c. CITY OR TOWN <b>Kansas City</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2422 Olive</b>		6. STREET ADDRESS (If outside, give location) <b>2422 Olive</b>	
Length of stay in lb <b>65 yrs.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>L.</b> Last <b>Reilly</b>		4. DATE OF DEATH Month <b>April</b> Day <b>10</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 26-1885</b>
9. AGE (In years last birthday) <b>71</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-clerk-timekeeper</b>	11. BIRTHPLACE (City and state or country) <b>Des Moines, Iowa</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-clerk-timekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Michael J. Reilly</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Ann O'Leary</b>	14. NAME OF HUSBAND OR WIFE <b>none</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>A 632-827</b>	17. INFORMANT Address <b>Carl Pat Reilly 2422 Olive</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>Arteriosclerotic Heart Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4200</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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>Myocardial Permeous Arteriosclerosis</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 _____ 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 _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Melody McGilley Eylar</b>		22b. ADDRESS <b>1034 North Blvd</b>	
22c. DATE SIGNED <b>4-13-57</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4-13-57</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City, Mo</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Melody-McGilley-Eylar, 1800 E. Linwood</b>		25. DATE RECD. BY LOCAL REG. <b>4-12-57</b>	
		26. REGISTRAR'S SIGNATURE <b>neva minshall</b>	



**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.