

Health, Welfare, Public Service

FILED SEP 24 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 32045  
Registrar's No. 4180

Registration District No. 149 Primary Registration District No. 1002

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>		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>St. Mary's Hosp.</b>		Length of stay in 1b <b>48 yrs</b>	d. STREET ADDRESS (If outside, give location) <b>5601 Lydia</b>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>NARCISSUS</b> Middle <b>JOSEPH</b> Last <b>MEUNIER</b>			4. DATE OF DEATH Month <b>Sept</b> Day <b>5</b> Year <b>1957</b>		
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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>July 2, 1876</b>	9. AGE (In years last birthday) <b>81</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Restuarant</b>	11. BIRTHPLACE (City and state or country) <b>Leopold, Indiana</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
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13a. FATHER'S NAME <b>Unknown Meunier</b>	13b. MOTHER'S MAIDEN NAME <b>Mary F. Pauporte</b>	14. NAME OF HUSBAND OR WIFE <b>Frances L. Meunier</b>
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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>None</b>	17. INFORMANT Address <b>Mrs. Frances L. Meunier, 5601 Lydia</b>
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18. CAUSE OF DEATH (Enter only one cause per line, or (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease c</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>4200'</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Coronary heart disease</b>		
DUE TO (c) <b>Recent fibrous atherosclerosis</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>---</b>
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20c. TIME OF INJURY Hour <b>---</b> Month <b>---</b> Day <b>---</b> Year <b>---</b> a.m. <b>---</b> p.m. <b>---</b>	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.) <b>---</b>	20f. CITY, TOWN, OR LOCATION <b>---</b>	COUNTY <b>---</b>	STATE <b>---</b>
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21. I attended the deceased from Death occurred at <b>1:15 pm</b> on <b>9/3/57</b> to <b>9/6/57</b> and last saw her/him alive on <b>9/5/57</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>[Signature]</b> (Degree or title) <b>MD</b>	22b. ADDRESS <b>1010 Pine Bluff K06 Ind. 9/6/57</b>	22c. STATE SIGNED <b>Mo</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>9-7-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Hickman Mills, Mo.</b>
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24. FUNERAL DIRECTOR <b>Melody-McGilley-Eylar Funeral Home</b> ADDRESS <b>1800 E. Linwood, K. C., Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>9-6-57</b>	26. REGISTRAR'S SIGNATURE <b>[Signature]</b>
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1800 E. Linwood, K. C., Mo. (Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

C. G. Leitch

Take to  
City Hall

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. 2999  
P. O. Address KC .....

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.