

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40478

FILED DEC 2 - 1957

STATE FILE NUMBER 5353

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

300
1-57

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> COUNTY <u>Jackson</u>	
b. CITY OR TOWN <u>Kansas City</u> (Outside corporate limits, give TOWNSHIP only) Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <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>Research Dept of 149</u> Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>2640 Harrison</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>FLORENCE Mc NERNEY</u>			4. DATE OF DEATH Month Day Year <u>11-12-57</u>		
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5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>unknown</u>	9. AGE (In years last birth) <u>gross</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>nurse</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>nurse</u>	11. BIRTHPLACE (City and state or country) <u>unknown</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>unknown</u>	13b. MOTHER'S MAIDEN NAME <u>unknown</u>	14. NAME OF HUSBAND OR WIFE <u>unknown</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or (N/A)) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>unknown</u>	17. INFORMANT <u>Jackson County Health Council</u> Address
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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>Cause of death undetermined</u>		INTERVAL BETWEEN ONSET AND DEATH <u>89715</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>fracturing. Laboratory Exam positive for bichloride mercuric</u>	
	DUE TO (c) <u>for bichloride mercuric</u>	
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 checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>bichloride mercuric</u>
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20c. TIME OF INJURY Hour a.m. p.m. <u>10-29-57</u>	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>Kansas City Jackson, Mo.</u>
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21. I attended the deceased from _____ to _____ and last saw her/him live on _____
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Hugh H. Owens</u> (Degree or title) <u>3</u>	22b. ADDRESS <u>1034 Realty Bldg</u>	22c. DATE SIGNED <u>11-12-57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>11-12-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sebathe Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Sebathe Kansas</u>
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24. FUNERAL DIRECTOR <u>H. Tequiman & Son's Inc.</u> ADDRESS <u>K.C. Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>11-13-57</u>	26. REGISTRAR'S SIGNATURE <u>neva Marshall</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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. Owens



AUG 2 1958

APR 2 1958

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 *G. LeRoy Mooney*

Licensed Embalmer No. *4776*
P. O. Address *T. C. Mooney*

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.