19

Health, Welfare Public Service

FILED FEB 13 1958

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

1263

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 344

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) Kansas City — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Wilhite Nursing — Length of stay in 1b Home 50 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 3139 Main St. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Mrs Nellie Middle Theresa Last Harrington

4. DATE OF DEATH Month Day Year Jan.21,1958

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH July 1878
9. AGE (In years last birthday) 79 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY At Home
11. BIRTHPLACE (City and state or country) County Mayo, Ireland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Patrick McGavick
13b. MOTHER'S MAIDEN NAME Mary McGavick
14. NAME OF HUSBAND OR WIFE Michael Harrington

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. 486-05-5907 D
17. INFORMANT Mrs Anna Marie O'Sullivan — Address 1200 West 97th St. Kansas City, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Myocardial Decompensation — 6 months
DUE TO (c) Generalized Inanition — 1 year
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 ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 11-2-54, to 1-21-58 and last saw her alive on 1-21-58
Death occurred at 10.20 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) [signature] DD
22b. ADDRESS 3 East 39th St., K. C., Mo
22c. DATE SIGNED 1-22-58

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE Jan.24,1958
23c. NAME OF CEMETERY OR CREMATORY St.Mary's
23d. LOCATION (City, town, or county) (State) Kansas City, Mo.

24. FUNERAL DIRECTOR Thomas E.Quirk — ADDRESS 4316 Troost Ave.
25. DATE RECD. BY LOCAL REG. 1-23-58
26. REGISTRAR'S SIGNATURE Neva Marshall

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in part I must be causally related.

Chas. G. Stephens

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.