

Health,  
Welfare  
Public  
Service

FILED APR 9 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-010016  
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1552

300  
-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> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City Mo</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Grandview</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lakeside</u>		Length of stay in lb <u>24 hrs</u>	d. STREET ADDRESS (If outside, give location) <u>12709 13th st.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Oliva</u> Middle <u>M.</u> Last <u>Kearney</u>			4. DATE OF DEATH Month <u>March</u> Day <u>22</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 12-1918</u>	9. AGE (In years last birthday) <u>39</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>

13a. FATHER'S NAME <u>Albert Eads</u>		13b. MOTHER'S M maiden name <u>Clara</u>		14. NAME OF HUSBAND OR WIFE <u>James Kearney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>James Kearney 12709 13th st.</u> Address <u>Grandview Mo.</u>	

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>CARCINOMATOSIS OF ENTIRE BODY</u>			INTERVAL BETWEEN ONSET AND DEATH <u>170h</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>CARCINOMA of Breast of lymph nodes</u>					
DUE TO (c) <u>Cirrhosis</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 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 <u>  </u> Month <u>  </u> Day <u>  </u> Year <u>  </u> a.m. <u>  </u> p.m. <u>  </u>					

20d. INJURY OCCURRED WHILE AT <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 <u>3-15-58</u> to <u>3-22-58</u> and last saw her alive on <u>3-22-58</u> Death occurred at <u>10:15 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>B. F. Waitert</u>			22b. ADDRESS <u>1204 Prospect, Grandview, Mo.</u>		22c. DATE SIGNED <u>3-24-58</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3-26-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Graceland Cemetery</u>	23d. LOCATION (City, town, or county) <u>R. C. Mo</u>	(State)
24. FUNERAL DIRECTOR <u>B. F. Waitert</u>		ADDRESS <u>ICP Mo</u>	25. DATE RECD. BY LOCAL REG. <u>3-25-58</u>	26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u>

(Licensed Embalmer's Statement on Reverse Side)

Friedman Weinberger USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MS  
FEB 29 1960

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 ..... *B. E. Weir*

Licensed Embalmer No. *4075*

P. O. Address *L. C. 8 Mo*

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.