

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-010017

STATE FILE NUMBER

1224

FILED MAR 31 1958

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

Health, Welfare, Public Service, 1300, 1-56, All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Director, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. Use only black ink or ribbon typewrite if possible. C. G. Leitch

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson							
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Cresthaven Home 3516 Summit			Length of stay in 15' 27 Yrs		d. STREET ADDRESS (If outside, give location) 6508 Rockhill Rd.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First William Middle M Last Kelly				4. DATE OF DEATH Month March Day 7 Year 1958							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 8, 1878		9. AGE (In years last birthday) 79		IF UNDER 1 YEAR Months 7 Days 17 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. (17) Trainman			10b. KIND OF BUSINESS OR INDUSTRY C.B. & Q RR Co.		11. BIRTHPLACE (City and state or country) St. Joseph, Mo.			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Michael Kelly				14. MOTHER'S MAIDEN NAME Johanna Sullivan							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.			16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Mrs Helen Waldron St. Joseph, Mo.						
18. CAUSE OF DEATH [Enter only one cause per line in (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease								INTERVAL BETWEEN ONSET AND DEATH 4 mos.			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Generalized arteriosclerosis		DUE TO (c) _____		?		4 mos			
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 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.) _____								
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month, Day, Year _____			_____								
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 Jan 1958 to 3/7/58 and last saw her/him alive on 3/7/58 Death occurred at 3.05 A m on the date stated above; and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) [Signature] M.D.				22b. ADDRESS 1010 Prof Bldg Kern				22c. DATE SIGNED 3/7/58			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Mar. 7, 1958		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet			23d. LOCATION (City, town, or county) (State) St. Joseph, Mo.				
24. FUNERAL DIRECTOR Norman W. [Signature] ADDRESS [Address]				25. DATE RECD. BY LOCAL REG. 3-7-58		26. REGISTRAR'S SIGNATURE neva minshall					

100-3-811

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 *Robert D. [Signature]*

Licensed Embalmer No. 33

P. O. Address *St. Joseph*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.