Health, & Welfare Public Service

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-036760
STATE FILE NUMBER

NOV 14 1958 Registration District No. 150 Primary Registration District No. 5572 Registrar's No. 242

1. PLACE OF DEATH
a. COUNTY: JACKSON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: RURAL-PRIARIE — Inside Limits: Yes ☐ No ☒
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: COUNTY HOSPITAL — Length of stay in Ib: 19 months

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY: JACKSON
c. CITY OR TOWN: KANSAS CITY — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (Inside, give location): 1413 SUMMIT — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: MARY Middle: E. Last: MAHONEY
4. DATE OF DEATH: Month: NOV. Day: 5 Year: 1958
5. SEX: FE.
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MAY-16-1907
9. AGE (In years last birthday): 51 — 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: HOME
11. BIRTHPLACE (City and state or country): CINCINNATI, OHIO
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME: (Unknown) Griffin
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: JOSEPH R. MAHONEY
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 500 22 5110
17. INFORMANT: J. R. MAHONEY — Address: 1413 SUMMIT - K.C. MO.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertensive Heart disease
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) General Arterio-sclerosis
DUE TO (c) Asthma

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 443X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

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 april 3-1957 to NOV. 5-1958 and last saw her/him alive on NOV. 5 1958
Death occurred at 6 8 m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Philip S. Japer (Degree or title) M.D.
22b. ADDRESS: Lees Summit, Mo
22c. DATE SIGNED: 11-5-58

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 11-8-58
23c. NAME OF CEMETERY OR CREMATORY: MT. OLIVET CEM.
23d. LOCATION (City, town, or county) (State): KANSAS CITY, MO.

24. FUNERAL DIRECTOR: MELLODY-McGILLEY-EYLAR — ADDRESS: 20 W. LINWOOD
25. DATE RECD. BY LOCAL REG.: 11/7/58
26. REGISTRAR'S SIGNATURE: N B Langford

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

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.