Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-001395
STATE FILE NUMBER

JAN 28 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 145

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY OR TOWN Kansas City — Inside Limits Yes XX No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Joseph Hospital — Length of stay in 1b 15 years

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 XX No ☐
d. STREET ADDRESS (If outside, give location) 3826 Agnes — Reside on Farm Yes ☐ No XX

3. NAME OF DECEASED (Type or print) First: MRS. Middle: NELLIE Last: LEARY
4. DATE OF DEATH Month: January Day: 8 Year: 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐
8. DATE OF BIRTH: 11-5-1874
9. AGE (In years last birthday): 84 — 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): Creston, Iowa
12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME: Henry McNeil
13b. MOTHER'S MAIDEN NAME: Isabell Duel
14. NAME OF HUSBAND OR WIFE: Frank Leary
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.: None
17. INFORMANT: Mr. Roy Leary — Address: 3826 Agnes - K.C., Mo.

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) Chr Myocarditis. — 3 mo.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Chr Nephritis — 1 year
DUE TO (c) Hypertension — 5 yrs.
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.) NO
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year NO
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ NO
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 1, 1959 to Jan 8, 1959 and last saw her/him alive on Jan 8, 1959
Death occurred at 9:45 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE M. B. Casebolt M.D. (Degree or title)
22b. ADDRESS 4000 Baltimore K.C. MO
22c. DATE SIGNED 1-9-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Jan. 11, 1959
23c. NAME OF CEMETERY OR CREMATORY: Holy Sepulcher
23d. LOCATION (City, town, or county) (State): Worth, Illinois

24. FUNERAL DIRECTOR ADDRESS: Stine & McClure Und. Co., K.C., Missouri
25. DATE RECD. BY LOCAL REG.: 1-9-59
26. REGISTRAR'S SIGNATURE: Nera Minshall

(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.

M. B. Casebolt

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 William M. Turner

Licensed Embalmer No. 4648

P. O. Address Kansas City, 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.