

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-004607
STATE FILE NUMBER

FILED FEB 16 1959

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 164

300
-57

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Joseph <i>1170</i> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph's Hosp.		Length of stay in lb Life	d. STREET ADDRESS (If outside, give location) 1931 Ashland Ave. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First MIDDLE Last LYDA MARIE O'MEARA			4. DATE OF DEATH Month Day Year February 10, 1959		
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5. SEX Female	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 Oct. 1, 1900	9. AGE (In years last birthday) 58	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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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) St. Joseph, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Dr. William L. Kenney	13b. MOTHER'S MAIDEN NAME Nellie Kenney	14. NAME OF HUSBAND OR WIFE Thomas B. O'Meara
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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. 491-03-3633	17. INFORMANT Thomas B. O'Meara	Address 1931 Ashland City
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia, Bronchial Sere</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Pneumonia 2 day P.O. Cholecystectomy</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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.) <i>586x</i>
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	
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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
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21. I attended the deceased from <i>1956</i> to <i>10 Feb 1959</i> and last saw her alive on <i>10 Feb 1959</i> Death occurred at <i>3:45 P</i> m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>J. J. Mothershead</i>	22b. ADDRESS <i>9603 Fredrick</i>	22c. DATE SIGNED <i>2-11-59</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Feb. 13, 59	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph, Mo.
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24. FUNERAL DIRECTOR <i>H. O. Sidenfaden & Son</i>	ADDRESS St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. <i>Feb. 12, 1959</i>	26. REGISTRAR'S SIGNATURE <i>Wm. Clark Standell</i>
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(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.
 Dr. J. J. Mothershead
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION

VS
MAY 27 1960

VS
MAY 24 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 *Robert H. Gable*
Licensed Embalmer No. 3308

P. O. Address St. Joseph, 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.