

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009536

STATE FILE NUMBER 1204

MAR 19 1959

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

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 General Hospital		Length of stay in 1b 9 Yrs.	d. STREET ADDRESS (If outside, give location) 1310 Troost Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last JACOB W. XXXXXXXX McMains			4. DATE OF DEATH Month Day Year March 3, 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 3, 1880
9. AGE (In years last birthday) 79		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) night watchman		10b. KIND OF BUSINESS OR INDUSTRY Garage	11. BIRTHPLACE (City and state or country) Crawford Co. Kansas 12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME William A. McMains		13b. MOTHER'S MAIDEN NAME Henrietta Alben	14. NAME OF HUSBAND OR WIFE none
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 519-09-9771	17. INFORMANT Edwain McMains Address St. Paul Kans.
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>Post traumatic Encephalomalacia</i> <i>Subdural Hemorrhage and</i> <i>Multiple Skull Fractures</i> 1988 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Subdural Hemorrhage and</i> DUE TO (c) <i>Multiple Skull Fractures</i> 1988 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <i>apparently was struck on head</i>	
20c. TIME OF INJURY Hour Month, Day, Year <i>7:45 AM 2-23-59</i>			
20d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, factory, street, office bldg., etc.) <i>Garage</i>	20f. CITY, TOWN, OR LOCATION <i>Kansas City</i>	COUNTY STATE <i>Jackson Mo</i>
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Geo C Kealhofer</i> (Degree or title)		22b. ADDRESS <i>6627 Broad St Kansas City Mo</i>	22c. DATE SIGNED <i>3-3-59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>removal</i>	23b. DATE <i>March 3, 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Hope Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>St. Paul, Kansas</i>
24. FUNERAL DIRECTOR Mellody-McGilley-Eylar, 1800 E. Linwood K.C., Mo.		25. DATE RECD. BY LOCAL REG. <i>3-5-59</i>	26. REGISTRAR'S SIGNATURE <i>neva myshall</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION
 All diseases in Part I must be causally related.
 Geo. C. Kealhofer

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 *James E. Kael*

Licensed Embalmer No. *4573*
P. O. Address *1109*

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.