

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017946

STATE FILE NO. 2535

FILED JUN 9 1959

Registration District No. 149 Primary Registration District No. 1602 Registrar's No.

300
-57

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
c. FULL NAME OF DECEASED Phillip Slattery		d. STREET ADDRESS 948 W. 33rd Terr.	
3. NAME OF DECEASED (Type or print) First PHILLIP Middle A. Last SLATTERY		4. DATE OF DEATH Month 5 Day 19 Year 59	
5. SEX Ma	6. COLOR OR RACE Wh	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Lawyer		10b. KIND OF BUSINESS OR INDUSTRY Law	11. BIRTHPLACE (City and state or country) St. Joseph, Mo.
13a. FATHER'S NAME Phillip Slattery		13b. MOTHER'S MAIDEN NAME Elizabeth B. Toohy	14. NAME OF HUSBAND OR WIFE XX
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. None	17. INFORMANT William Slattery, Perry, Iowa
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) Arterio sclerosis DUE TO (c) 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 3 days 20 yrs
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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.)		20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____	
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 3/19/59 to 5/19/59 and last saw her/him alive on 5/19/59 Death occurred at 9:00 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Joseph A. Fogarty (Degree or title) D.O.		22b. ADDRESS 402 Northman Rd. N. 69 Mo	22c. DATE SIGNED 5/21/59
23a. BURIAL, CREMATION, OR REMOVAL (Specify)	23b. DATE 5-22-59	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City, town, or county) (State) St. Joseph Mo.
24. FUNERAL DIRECTOR Wagner Funeral Home, 266 200		25. DATE RECD. BY LOCAL REG. 5-21-59	26. REGISTRAR'S SIGNATURE Neva Marshall

MEDICAL CERTIFICATION
Joseph A. Fogarty USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

ME 1-4644

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 *Chris R. Hauschke*

Licensed Embalmer No. *4159*

P. O. Address *R. C. 71*

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.