THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-021535
STATE FILE NUMBER

FILED JUL 8 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2955

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City — Inside Limits Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Little Sisters Home — Length of stay in Hospital

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 (If outside, give location) 5331 Highland Ave. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: Miss Middle: Margaret Last: McQuinn

4. DATE OF DEATH Month June Day 16 Year 1959

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Feb.29,1878
9. AGE (In years last birthday) 80 years — 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) At Home
10b. KIND OF BUSINESS OR INDUSTRY Housework
11. BIRTHPLACE (City and state or country) Plattsburg,Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Bartholomew McQuinn
13b. MOTHER'S MAIDEN NAME Mary Ann Sullivan
14. NAME OF HUSBAND OR WIFE ----------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. None
17. INFORMANT Miss Catherine O'Connor Address 705 E.39th K.C.Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 Days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerosis — 20 years
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 332x

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.)
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 3-19-1954, to 6-16-1959 and last saw her/him alive on 6-16-59
Death occurred at ~~6-16-59~~ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Joseph A. Fogarty M.D. (Degree or title)
22b. ADDRESS 402 Wirthman Bldg K.C.10,Mo.
22c. DATE SIGNED 6-17-5

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal (Auto)
23b. DATE June 18,1959
23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery
23d. LOCATION (City, town, or county) (State) Plattsburg,Mo.

24. FUNERAL DIRECTOR South Side Chapel
ADDRESS 6900 Troost Ave.
25. DATE RECD. BY LOCAL REG. 6-17-59
26. REGISTRAR'S SIGNATURE Neva Minshall

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

Joseph A. Fogarty

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.