

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-021580

STATE FILE NUMBER
REGISTRAR'S NO. 3038

FILED JUL 8 1959

Registration District No. 149 Primary Registration District No. 1002

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		c. CITY OR TOWN Kansas City	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Trinity Lutheran Hosp.		d. STREET ADDRESS (If outside, give location) 3822 Benton Blvd	

3. NAME OF DECEASED (Type or print) First ANNA Middle M. Last MULLANE			4. DATE OF DEATH Month 6 - Day 20 - Year 59			
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. 8, 1888		9. AGE (In years last birthday) 70	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and state or country) Kansas City, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Patrick Casey	13b. MOTHER'S MAIDEN NAME Anna Barry	14. NAME OF HUSBAND OR WIFE Patrick P. Mullane
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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. None	17. INFORMANT Patrick J. Mullane, 6116 Blue Hills Road
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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) Intestinal Cancer		INTERVAL BETWEEN ONSET AND DEATH 2 years
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) 1539		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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT <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 May 20, 1959 to June 20, 59 and last saw her alive on 6/19/59 Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE H.S. Prentiss M.D. (Degree or title)	22b. ADDRESS Rialto Bldg - K. C., Mo.	22c. DATE SIGNED 6-20-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6-22-59	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
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24. FUNERAL DIRECTOR Melody-McGilley-Eylar, 20 W. Linwood	25. DATE RECD. BY LOCAL REG. 6-22-59	26. REGISTRAR'S SIGNATURE Neve Marshall
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

H. S. Prentiss

Not necessary in Part I must be causally related.

U.S. (Practices), Unit
113-5172
11:30 am to 2:30 PM.
Complete info. on
before filing.

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 *Wm H Denty*
Licensed Embalmer No. *05038*
P. O. Address *K.C. 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.