

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 14 1959

59-025010

Registration District No. 49 Primary Registration District No. 1002 Registrar's No. 3701 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>32 years</u>	c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Downtown Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3411 Gillham Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Patrick</u> Middle <u>BRENNAN</u> Last <u>BRENNAN</u>			4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 3, 1900</u>	9. AGE (last birthday) <u>59</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grain Master</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mo. State Grain Assn</u>	11. BIRTHPLACE (City and state or country) <u>Ireland</u>	12. CITIZEN OF WHAT COUNTRY <u>USA.</u>	
13a. FATHER'S NAME <u>Thomas Brennan</u>		13b. MOTHER'S MAIDEN NAME <u>Bridgett Cunknow</u>	14. NAME OF HUSBAND OR WIFE <u>MARGARET R. BRENNAN</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>486-36-5905</u>	17. INFORMANT <u>MARGARET BRENNAN 3411 Gillham Rd.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident with Hemorrhage (Left Hemisphere-with Right-Sided Weakness</u> DUE TO (b) <u>Hypertensive Arteriosclerotic Heart Disease</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>2 Days</u> <u>3-4 Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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 <u>8-15-1951</u> to <u>7-29-59</u> and last saw <u>him</u> live on <u>7-29-59</u> Death occurred at <u>3:00 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>E. Robert Theard M.D.</u>			22b. ADDRESS <u>1222 McGee St., K.C., Mo.</u>		22c. DATE SIGNED <u>7-31-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Aug. 1, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Angel Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hoge, KANSAS</u>	
24. FUNERAL DIRECTOR <u>Muehlebach</u>		ADDRESS <u>6800 TROOST</u>	25. DATE RECD. BY LOCAL REG. <u>7-31-59</u>	26. REGISTRAR'S SIGNATURE <u>Irene Minshel</u>	

DOCUMENT

BY AFFIDAVIT OF  
ROBERT NIGRO MEDICAL CERTIFICATION

1222 71  
6:00 PM

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed J. Crowell

Licensed Embalmer No. 490

P. O. Address H. C. M.

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.