

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 14 1959

59-025095

Registration District No. 49 Primary Registration District No. 1002 Registrar's No. 3643 STATE FILE NUMBER

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		Length of stay in 1b 52 yrs.	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 St. Luke's Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 29 East 53rd Street Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Frank Middle K. Last Egan			4. DATE OF DEATH Month July Day 27 Year 1959			
---	--	--	--	--	--	--

5. SEX Male	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 8-27-1906	9. AGE (last birthday) 52	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
-----------------------	----------------------------------	---	--------------------------------------	-------------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Estimating Engineer	10b. KIND OF BUSINESS OR INDUSTRY R.B. Potashnick Co.	11. BIRTHPLACE (City and state or country) Kansas City, Missouri	12. CITIZEN OF WHAT COUNTRY USA
---	---	--	---

13a. FATHER'S NAME John F. Egan	13b. MOTHER'S MAIDEN NAME Catherine Stretch	14. NAME OF HUSBAND OR WIFE Lois Egan
---	---	---

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. 562-03-9207	17. INFORMANT Address Mrs. Lois Egan, 29 East 53rd St. K. C. Mo.
---	---	--

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 Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 6 hrs
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)	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 _____ a.m. _____ p.m. Month _____ Day _____ Year _____	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 Kansas City	COUNTY Missouri	STATE
---	--	--	--	---------------------------	-------

21. I attended the deceased from July 27 9am-59 to July 27-59 and last saw him alive on July 27, 1959 Death occurred at 118 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.	
--	--

22a. SIGNATURE M. G. Berry M.D. (Degree or title)	22b. ADDRESS 315 Nichols Rd Kansas City, Mo	22c. DATE SIGNED July 28 59
---	---	---------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7-30-59	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
--	-----------------------------	--	---

24. FUNERAL DIRECTOR ADDRESS Melody-McGilley-Eylar, 20 W. Linwood	25. DATE RECD. BY LOCAL REG. 7-28-59	26. REGISTRAR'S SIGNATURE Neve Marshall
---	--	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF M. G. Berry

Dr. Maxwell
Plaza Me
Va 1-3243

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 W. A. Benty

Licensed Embalmer No. 5030

P. O. Address K.C. Me

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.