

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025151

FILED VS JUL 31 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3481 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 lb <u>50 Yrs</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>St. Marys Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3808 Virginia</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>J</u> Last <u>GRIFFIN</u>				4. DATE OF DEATH Month <u>7</u> Day <u>15</u> Year <u>59</u>								
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Jul 19-1881</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HR Hours <u>0</u> Min. <u>0</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Private Nursing</u>		11. BIRTHPLACE (City and state or country) <u>Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>					
13a. FATHER'S NAME <u>John O'Donnell</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>			14. NAME OF HUSBAND OR WIFE <u>George W. Griffin</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>488-36-0586</u>		17. INFORMANT <u>Mrs. Margaret Bloodhart</u>				Address				
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>M. yeastoid infection</u> DUE TO (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>arteriosclerotic heart disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 week</u> <u>10 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 <u>5-10</u> a.m. <u>P.M.</u> Month, Day, Year <u>Jan 10 59</u>		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 <u>Kansas City, Missouri</u>	
21. I attended the deceased from <u>Jan 10 59</u> to <u>July 15-59</u> and last saw her <u>live</u> on <u>July 15, 1959</u>				Death occurred at <u>5-10 P.M.</u> m on the date stated above, and to the best of my knowledge from the causes stated.								
22a. SIGNATURE <u>T. J. Burke M.P.</u> (Degree or title)				22b. ADDRESS <u>1207 Rialto Bldg. KC Mo.</u>			22c. DATE SIGNED <u>7-16-59</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>7-18-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Marys Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>							
24. FUNERAL DIRECTOR <u>Mellody-McGilley-Eylar - Linwood - Woodland</u>				25. DATE RECD. BY LOCAL REG. <u>7-16-59</u>		26. REGISTRAR'S SIGNATURE <u>Neve Minshall</u>						

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF T. J. Burke

Griffin
Mr Lally
Rialto Bldg
V.I. 2-3345
In 2³⁰ - 4⁰⁰

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 George A. Jackson

Licensed Embalmer No. 5059

P. O. Address K. C. M.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.