

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-025232

STATE FILE NUMBER 3482

FILED VS JUL 31 1959

Registration District No. 149 Primary Registration District No. 1002

Registrar's No.

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>General Hospital #2</b>		Length of stay in lb <b>Life</b>	d. STREET ADDRESS (If outside, give location) <b>3934 Bellfontaine</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Georgia</b> Middle <b>Jean</b> Last <b>Kelly</b>			4. DATE OF DEATH Month <b>July</b> Day <b>14</b> Year <b>1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 8, 1935</b>	9. AGE (In years last birthday) <b>34 years</b> 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) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>Kansas City, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>George Rieke</b>		13b. MOTHER'S MAIDEN NAME <b>Hazel Mountjoy</b>		14. NAME OF HUSBAND OR WIFE <b>Thomas J. Kelly</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>488-22-2228</b>	17. INFORMANT <b>Tom Kelly</b> Address <b>3934 Bellfontaine</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple sclerosis.</b>					INTERVAL BETWEEN ONSET AND DEATH
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) <b>Pyleonephritis</b>					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 COUNTY STATE		
21. I attended the deceased from <b>12-10-58</b> to <b>7-14-59</b> and last saw her alive on <b>7-14-59</b> Death occurred at <b>6:30 Pm</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Dr. Frank Ellis</i> (Degree or title)			22b. ADDRESS <b>600 East 22nd Street</b>		22c. DATE SIGNED <b>7-15-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>July 17, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. St. Mary's</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City, Mo.</b>	
24. FUNERAL DIRECTOR <b>Wornall Funeral Home</b> ADDRESS <b>K.C. Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>7-16-59</b>	26. REGISTRAR'S SIGNATURE <i>Neve Marshall</i>		

MEDICAL CERTIFICATION  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
E. Frank Ellis

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Thomas J. [Signature]*

Licensed Embalmer No. *3773*  
P. O. Address *[Signature]*

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.