

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-036279

FILED VS NOV 2 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4995 STATE FILE NUMBER

UNRECORDED

| | | | | | | | |
|--|----------------------------------|---|--|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Jackson | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Wyandotte | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) Kansas City | | | Length of stay in 1b 3 yrs | | c. CITY OR TOWN Kansas City | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF HOSPITAL OR INSTITUTION <i>Conv. Home</i> 309 Garfield | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 6601 Webster | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Frank Middle McCleary Last McCleary | | | | 4. DATE OF DEATH Month Oct. Day 15, Year 1959 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH May 3, 1888 | 9. AGE (last birthday) 71 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Machinist for Rail | | 11. BIRTHPLACE (City and state or country) McKeesport, Pa. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME John C. McCleary | | | 13b. MOTHER'S MAIDEN NAME Unknown | | 14. NAME OF HUSBAND OR WIFE Lucy A. McCleary | | |
| 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. 487-14-2123A | | 17. INFORMANT Carroll G. McCleary, 6601 Webster, kck. | | |
| 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 DUE TO (b) Arteriosclerosis DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 day 8 years | |
| 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 | | COUNTY STATE | |
| 21. I attended the deceased from 1-15-59 to 10/15/59 and last saw him alive on 10-15-59 Death occurred at 6:15 PM on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE <i>Frank Paul Lawrence</i> MD | | | | 22b. ADDRESS 428 S. White K.C.Mo | | 22c. DATE SIGNED 10/16/59 | |
| 23a. FUNERAL CREATION, REMOVAL (Specify) Burial | | 23b. DATE Oct. 17, 1959 | | 23c. NAME OF CEMETERY OR CREMATORY Mt Calvary | | 23d. LOCATION (City, town, or county) (State) Kansas City, Kansas | |
| 24. FUNERAL DIRECTOR Jos. A. Butler's Sons, K.C.Kan. | | | | 25. DATE RECD. BY LOCAL REG. 10-17-59 | | 26. REGISTRAR'S SIGNATURE <i>Wm Marshall</i> | |

DOCUMENT

BY AFFIDAVIT OF Frank Paul Lawrence, M.D. MEDICAL CERTIFICATION

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 Ralph O. Grubb

Licensed Embalmer No. 5004

P. O. Address K. C. Kan.

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.