URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

59-039937
STATE FILE NUMBER

FILED VS DEC 10 1959 Registration District No. 19 Primary Registration District No. 1602 Registrar's No. 5684

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City
Length of stay in 1b: 77 Years
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 7505 E. 87 Terr.
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Jackson
c. CITY OR TOWN Kansas City
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 615 E. 16th
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: Mamie Middle: Last: Brophy
4. DATE OF DEATH Month Day Year: Nov. 24, 1959
5. SEX: Female
6. COLOR OR RACE: Cauc.
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: Nov 15, 1882
9. AGE (last birthday): 77
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)
10b. KIND OF BUSINESS OR INDUSTRY: Hospital
11. BIRTHPLACE (City and state or country): Kansas City, Kansas
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Elijah McClain
13b. MOTHER'S MAIDEN NAME: Mirilla Bolin
14. NAME OF HUSBAND OR WIFE: Edward Brophy
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 487-12-8619
17. INFORMANT: Mrs. Claude J. Scott Address: 7505 E. 87th Terr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypostatic Pneumonia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Cerebral Vascular Accident
DUE TO (c) Arteriosclerosis
INTERVAL BETWEEN ONSET AND DEATH
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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 Sept 11, 1959, to Nov. 24, 1959 and last saw her/him alive on Nov 24, 1959
Death occurred at Curtis Nursing Home - K.C. Mo. 9 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE J. D. Schwab (Degree or title) D.O.
22b. ADDRESS 13121 U.S. 71 Grandview, Mo
22c. DATE SIGNED 11-25-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: Nov 27, 1959
23c. NAME OF CEMETERY OR CREMATORY: Mt. Hope Cemetery
23d. LOCATION (City, town, or county) (State): Kansas City, Kansas
24. FUNERAL DIRECTOR: Muehlebach ADDRESS: 6800 Troost
25. DATE RECD. BY LOCAL REG.: 11-25-59
26. REGISTRAR'S SIGNATURE: Neva Marshall

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF J. D. Schwab

Wa 1-0572
Sptemmer Card

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed J. T. Crowell
Signature of Student Embalmer

Licensed Embalmer No. 4904

P. O. Address K.C. Mo

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