

**MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-040062**

**FILED VS NOV 23 1959**

149

Registration District No. 1002

Registrar's No.

**5339**

STATE FILE NUMBER

MEMORANDUM

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>	Length of stay in 1b <b>3 years</b>	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>3649 The Paseo</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3649 The Paseo</b>

3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>Christopher</b> Last <b>Glynn</b>			4. DATE OF DEATH Month <b>November</b> Day <b>4</b> Year <b>1959</b>	
--	--	--	---	--

5. SEX <b>Male</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>12/24/1888</b>	9. AGE (last birthday) <b>74</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
-----------------------	----------------------------------	---	---------------------------------------	-------------------------------------	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nat'l Screen Corp Motion Pictures</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Kansas City Missouri</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
---	-----------------------------------	---	--

13a. FATHER'S NAME <b>Thomas Glynn</b>	13b. MOTHER'S MAIDEN NAME <b>Margaret McMahan</b>	14. NAME OF HUSBAND OR WIFE <b>Nelle Glynn GLYNN</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>497-26-0287</b>	17. INFORMANT <b>Mrs. Nelle Glynn 3649 The Paseo</b>
---	---	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Sudden Coronary embolus</b>		<b>Sudden</b>
DUE TO (b) <b>Chronic Fibrillation</b>		<b>1 yr</b>
DUE TO (c) <b>Chronic hypertension + Rheumatic heart disease</b>		
PART II. OTHER SIGNIFICANT CONDITION CONTRIBUTING TO DEATH (If not related to the terminal disease condition given in PART I) <b>Had bad teeth pulled last Aug &amp; started going down hills right away. Severe &amp; short breath.</b>		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.) <b>none</b>
---	---	---

20c. TIME OF INJURY Hour <b>none</b> a.m. <b>none</b> p.m. <b>none</b>
---

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>none</b>	20f. CITY, TOWN, OR LOCATION <b>none</b>	COUNTY <b>none</b>	STATE <b>none</b>
---	---	---	-----------------------	----------------------

21. I attended the deceased from <b>Jan 1, 1959</b> to <b>Nov 4, 1959</b> and last saw her/him alive on <b>Oct 3 1959</b> Death occurred at <b>his home</b> <b>5:30 P</b> on the date stated above, and to the best of my knowledge, from the causes stated.
---

22a. SIGNATURE (Degree or title) <b>Harvey Jennett, M.D.</b>	22b. ADDRESS <b>1500 Professional Bldg Kansas City Mo</b>	22c. DATE SIGNED <b>11-5-59</b>
---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>11/7/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Washington Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City Missouri</b>
--	-------------------------------	--	--

24. FUNERAL DIRECTOR <b>D.W. Newcomers Sons 1331 Brush Creek Blvd. Kansas City Missouri</b>	25. DATE RECD. BY LOCAL REG. <b>11-6-59</b>	26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>
--	--	---

DOCUMENT

BY AFFIDAVIT OF HARVEY JENNETT MEDICAL CERTIFICATION

74

Apr 1 1920

**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 Robert F. Tuller

Licensed Embalmer No. 4818

R.O. Address KC Mo

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.