

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-001721

FILED VS JAN 19 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 50 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 61 yrs		c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St Lukes Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 200 W. 53 rd. st. Terr		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle E. Last McDonnell				4. DATE OF DEATH Month Jan. Day 2, Year 1960				
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Nov. 16, 1872	9. AGE (last birthday) 87	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <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) Co-Founder Burns & McDonnell Engineering			10b. KIND OF BUSINESS OR INDUSTRY Montana		11. BIRTHPLACE (City and state or country) U. S. A.		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME John McDonnell			13b. MOTHER'S MAIDEN NAME Harriet Stuff			14. NAME OF HUSBAND OR WIFE Georgia McDonnell		
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. —		17. INFORMANT Address Robert H. McDonnell 200 W. 53rd. Ter			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Encephalomalacia, cerebral & Basal Ganglia							INTERVAL BETWEEN ONSET AND DEATH 2+ Years	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral Arteriosclerosis							"	
DUE TO (c) General Arteriosclerosis							"	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 1) Arteriosclerotic Heart Disease 2) Chronic Cystitis					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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		Month, Day, Year						
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.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE
21. I attended the deceased from Sept. 27, 1957 , to 2 Jan. 1960 and last saw ^{her} him live on 2 Jan. 1960 Death occurred at 6:10 AM on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) Philip G. Kaul M.D.				22b. ADDRESS 911 Nichols Road			22c. DATE SIGNED 1-9-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/5/60	23c. NAME OF CEMETERY OR CREMATORY Calvary		23d. LOCATION (City, town, or county) (State) Kansas City Mo.			
24. FUNERAL DIRECTOR ADDRESS Stine & McClure K. C. Mo.			25. DATE RECD. BY LOCAL REG. 1-5-60		26. REGISTRAR'S SIGNATURE Neve Marshall			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF
Philip G. Kaul

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

Thomas A. Kee

Licensed Embalmer No. 499-

P. O. Address Ke.

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.