

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-006207

FILED VS MAR 7 1960

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 989 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 lb 13yrs.		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 Haven Manor Nursing Home			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 7627 Belleview		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle JOSEPH Last CONNAUGHTON				4. DATE OF DEATH Month Feb. Day 16, 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 9-19-85	9. AGE (last birthday) 74	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) Ret.- Credit Mgr.			10b. KIND OF BUSINESS OR INDUSTRY Lumber Co.		11. BIRTHPLACE (City and state or country) Graceville, Minn.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Peter Connaughton			13b. MOTHER'S MAIDEN NAME Mary Ellen O'Sullivan			14. NAME OF HUSBAND OR WIFE Leah L. Connaughton		
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. 491-32-5206		17. INFORMANT Address Violet J. Connaughton - 7627 Belleview			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia							INTERVAL BETWEEN ONSET AND DEATH one week	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Generalized Arterial Sclerosis							Years Years	
DUE TO (c)								
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"/> N. <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 1952 to 2-16-60 and last saw her/him alive on 2-16-60 Death occurred at 9:40p on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) Thos. P. McHale MD MD				22b. ADDRESS 4620 Independence - K.C., Mo.			22c. DATE SIGNED 2-17-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-19-60	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Kansas City 33, Mo.			
24. FUNERAL DIRECTOR Melody-McGilley-Eylar			ADDRESS 1800 E. Linwood		25. DATE RECD. BY LOCAL REG. 2-19-60		26. REGISTRAR'S SIGNATURE Neva Marshall	

DOCUMENT

MEDICAL CERTIFICATION
BY AFFIDAVIT OF
Thos. P. McHale

*Hand in the State
of Michigan
James*

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____, Student Embalmer No. _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James R. Phillips

Licensed Embalmer No. 4641
P. O. Address K. City, Mo.

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.