

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

**-60-030726**

**FILED VS SEP 12 1960**

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4405

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kansas</b> b. COUNTY <b>Wyandotte</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>6 weeks</b>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>746 Tauromee Avenue</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>(MRS.) CATHERINE CECILIA O'DOWER</b>			4. DATE OF DEATH Month Day Year <b>August 26, 1960</b>			
-----------------------------------------------------------------------------------------------------	--	--	--------------------------------------------------------------	--	--	--

5. SEX <b>Female</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>10-17-1877</b>	9. AGE (last birthday) <b>82</b>	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) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>	11. BIRTHPLACE (City and state or country) <b>Kansas City, Kansas</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
-----------------------------------------------------------------------------------------------------------------	-----------------------------------------------------	--------------------------------------------------------------------------	----------------------------------------------

13a. FATHER'S NAME <b>Nicholas Lawless</b>	13b. MOTHER'S MAIDEN NAME <b>Mary Jane Rhodes</b>	14. NAME OF HUSBAND OR WIFE <b>Wm. Edw. O'Dower</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>None</b>	17. INFORMANT Address <b>Wm. E. O'Dower, 746 Tauromee, K.C.K.</b>
-----------------------------------------------------------------------------------------------------------------------	----------------------------------------	----------------------------------------------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive and Atherosclerotic Heart Disease</b> <del>Stroke</del> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <b>Pulmonary Infarction</b> <del>Stroke</del>		INTERVAL BETWEEN ONSET AND DEATH <b>6 years</b> <b>6 wks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (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 Month, Day, Year a.m. p.m.	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 <u>1954</u> to <u>Aug 26, 1960</u> and last saw her alive on <u>Aug 24, 1960</u> Death occurred at <u>535 P.M.</u> on the date stated above, and to the best of my knowledge from the causes stated.
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

22a. SIGNATURE (Degree or title) <b>I. F. Steffen M.D.</b>	22b. ADDRESS <b>1103 Grand Ave. K.C. Mo</b>	22c. DATE SIGNED <b>8-26-60</b>
---------------------------------------------------------------	------------------------------------------------	------------------------------------

23a. BURIAL, CREMATION REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>8-29-1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City, Kansas</b>
------------------------------------------------------------	-------------------------------	------------------------------------------------------------------	-----------------------------------------------------------------------------

24. FUNERAL DIRECTOR <b>The Nugent Funeral Home, 1900 Central Ave.</b>	25. DATE RECD. BY LOCAL REG. <b>8-27-60</b>	26. REGISTRAR'S SIGNATURE <b>H. S. Dwyer</b>
---------------------------------------------------------------------------	------------------------------------------------	-------------------------------------------------

**Kansas City, Kansas**

DOCUMENT

MEDICAL CERTIFICATION

I. F. Steffen

BY AFFIDAVIT OF

