RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-038471

FILED VS OCT 31 1960 149 Registration District No. Primary Registration District No. 1002 Registrar's No. 5029 STATE FILE NUMBER

NDED

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 70 yrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 339 Spruce — Inside Limits Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Jackson
c. CITY OR TOWN Kansas City — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 339 Spruce — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print) First Martin Middle Last Meaney
4. DATE OF DEATH Month 10 Day 5 Year 1960
5. SEX male
6. COLOR OR RACE white
7. Married [ ] Never Married [ ] Widowed [X] Divorced [ ]
8. DATE OF BIRTH 11-6-1870
9. AGE (last birthday) 89 — 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) Eng.
10b. KIND OF BUSINESS OR INDUSTRY Ma O. P.
11. BIRTHPLACE (City and state or country) County Clair Ireland
12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME No Record
13b. MOTHER'S MAIDEN NAME No Record
14. NAME OF HUSBAND OR WIFE Catherine Meaney (Dec)
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. none
17. INFORMANT Address R G Burns 317 So Jackson K C Mo

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) Multiple fractures of skull
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Massive subdural hemorrhage
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. [ ] Yes [ ] No [ ] Unknown

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]
20a. ACCIDENT [X] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Fell down stairway
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 10-5-60
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home
20f. CITY, TOWN, OR LOCATION Kansas City COUNTY Jackson STATE Mo

21. I attended the deceased from _____, to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Geo C. Kealhofer M.D. Deputy Coroner
22b. ADDRESS 6622 Prospect Kans
22c. DATE SIGNED 10-5-60
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 10-8-1960
23c. NAME OF CEMETERY OR CREMATORY St Mary's Cemetery
23d. LOCATION (City, town, or county) (State) Kansas City Missouri
24. FUNERAL DIRECTOR Sheil Funeral Home ADDRESS 6606 Independence K.C. Mo.
25. DATE RECD. BY LOCAL REG. 10-6-60
26. REGISTRAR'S SIGNATURE H. L. Dwyer

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Geo. C. Kealhofer

STATEMENT BY LICENSED EMBALMER

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

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

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