

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-013911

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1907

FILED MAY 8 1961

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Length of stay in 1b <u>74 years</u>	c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Linwood Nursing Home</u> <u>1900 Linwood</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3424 Campbell</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>J.</u> Last <u>O'Donnell</u>			4. DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>1961</u>			
---	--	--	---	--	--	--

5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Cauc.</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 14 1886</u>	9. AGE (last birthday) <u>74</u>	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) <u>Laborer - Mfg. Co.</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Butler Mfg. Co.</u>	11. BIRTHPLACE (City and state or country) <u>Kansas City MO.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
--	---	--	--

13a. FATHER'S NAME <u>Patrick O'Donnell</u>	13b. MOTHER'S MAIDEN NAME <u>Ann Hackett</u>	14. NAME OF HUSBAND OR WIFE <u>Ida O'Donnell</u>
--	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO.	17. INFORMANT <u>Mrs. Thomas Ross</u> Address <u>3424 Campbell</u>
---	-------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage -</u> DUE TO (b) <u>Hypertension -</u> DUE TO (c) <u>Artero-sclerosis.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> <u>?</u>
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"/> 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 _____ 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 <u>April 15/61</u> to <u>April 18-61</u> and last saw her/him alive on <u>April 17-61</u> Death occurred at <u>7: a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Edwin C. Carrier, M.P.</u>	22b. ADDRESS <u>315 Nichols Blvd.</u>	22c. DATE SIGNED <u>4/18/61</u>
---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>April 20, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. Olive</u>	23d. LOCATION (City, town, or county) <u>Kansas City Missouri</u>
--	------------------------------------	--	--

24. FUNERAL DIRECTOR <u>Muehlebach</u> ADDRESS <u>6800 Troost</u>	25. DATE RECD. BY LOCAL REG. <u>4-18-61</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>
---	--	---

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 C. Carrier
 SHOULD READ
 ITEM NO.

Dr. Carrier
Plaza Med. Bldg.

Va 1-3434

after 2:00 PM Tues.

STATEMENT BY LICENSED EMBALMER

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

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

R. E. Nichols

Licensed Embalmer No. 4997

P. O. Address K. C. Med

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.