

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2223 STATE FILE NUMBER 61-017626

DATE AMENDED

INSTEAD OF

DOCUMENT

BY AFFIDAVIT OF

ITEM NO.

SHOULD READ

FILED MAY 19 1961

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 40 yrs.
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Little Sisters Of The Poor Inside Limits No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE Missouri b. COUNTY Jackson
 c. CITY OR TOWN Kansas City Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) 4608 E. 6th St. Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First William Middle B. Last McDaniel 4. DATE OF DEATH Month May Day 4 Year 1961

5. SEX Male 6. COLOR OR RACE White 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 6/21/1886 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) Sales 10b. KIND OF BUSINESS OR INDUSTRY Auto 11. BIRTHPLACE (City and state or country) Mankato Kansas 12. CITIZEN OF WHAT COUNTRY U. S. A.

13a. FATHER'S NAME Unknown 13b. MOTHER'S MAIDEN NAME Unknown 14. NAME OF HUSBAND OR WIFE Mina McDaniel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No. INFORMANT L. F. McDANIEL Address K.C. Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Lobar Pneumonia INTERVAL BETWEEN ONSET AND DEATH 5 days
 DUE TO (b) Arterio sclerosis 10 yrs
 DUE TO (c) _____
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

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 NO 20a. ACCIDENT SUICIDE HOMICIDE 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 .
 s.m. p.m.

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 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 3/19/51 to 5/4/61 and last saw ^{him} _{her} alive on 5/3/61
 Death occurred at 7:40 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Name or title) Joseph A. Fogarty 22b. ADDRESS 402 Northman Bldg. 69116 22c. DATE SIGNED 5/5/61

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE 5/7/61 23c. NAME OF CEMETERY OR CREMATORY FLORAL HILLS 23d. LOCATION (City, town, or county) (State) K.C. Mo.

24. FUNERAL DIRECTOR Stine & McClure ADDRESS Kansas City, Mo. 25. DATE RECD. BY LOCAL REG. 5-5-61 26. REGISTRAR'S SIGNATURE Ruth Long

1:00

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 William M. Turner

Licensed Embalmer No. 4648

P. O. Address Kansas City

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.