

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-001611

546

STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 546

FILED FEB 15 1962

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>		c. CITY OR TOWN <u>Kansas City</u>	
Length of stay in 1b <u>32 yrs.</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>St. Joseph Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>719 Cypress</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Joseph</u> Last <u>Devine</u>			4. DATE OF DEATH Month <u>January</u> Day <u>29</u> Year <u>1962</u>			
--	--	--	---	--	--	--

5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</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>2-21-1882</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>
--------------------	-------------------------------	---	-----------------------------------	----------------------------------	---	--

10a. USUAL OCCUPATION (Give kind of work done during life, even if retired) <u>Manager &amp; Leaser</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Mine</u>	11. BIRTHPLACE (City and state or country) <u>Shrewsburg, W. Va.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
---	--	--	---

13a. FATHER'S NAME <u>James Devine</u>	13b. MOTHER'S MAIDEN NAME <u>Bridgett Dorsey</u>	14. NAME OF HUSBAND OR WIFE <u>Delia Devine</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. <u>  </u>	17. INFORMANT <u>Rt. Rev. James E. Devine - Washington</u>	Address <u>39th. Terr. &amp;</u>
--	-----------------------------------	--	----------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
DUE TO (b) <u>Acute myocardial infarction</u>		<u>6 days</u>
DUE TO (c) <u>Acute occlusion of Right Coronary artery</u>		<u>3 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Coronary arteriosclerosis</u>		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 <u>  </u> a.m. <u>  </u> p.m. <u>  </u>	Month, Day, Year <u>  </u>
---	----------------------------

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>  </u> COUNTY <u>  </u> STATE <u>  </u>
---	--	---

21. I attended the deceased from <u>7-28-45</u> to <u>1-29-62</u> and last saw him alive on <u>1-29-62</u> . Death occurred at <u>11:30 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) <u>Thos. C. McHale M.D.</u>	22b. ADDRESS <u>4601 Indep. Ave. KC Mo</u>	22c. DATE SIGNED <u>1-30-62</u>
--	--	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2-1-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>
---	-------------------------	--	--

24. FUNERAL DIRECTOR <u>Mellody-McGilley-Eylar</u> ADDRESS <u>Woodland</u>	25. DATE RECD. BY LOCAL REG. <u>1-30-62</u>	26. REGISTRAR'S SIGNATURE <u>Ruth H. Long</u>
--	---	---

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 INSTEAD OF  
 DOCUMENT  
 16  
 500-20-9926  
 BY AFFIDAVIT OF Funeral Director  
THOMAS C. McHALE MD MEDICAL CERTIFICATION

Mr. Thomas W. C.  
4601 Indep. Ave.  
Ch. 1-5750  
Tues.  
2:00 to 5:00

**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 Gerald A. Burges

Licensed Embalmer No. 4763

P. O. Address K. C. 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.