

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-031039

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4185

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

1
2 370
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4 1
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9 420.1
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED AUG 28 1962	
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Jackson</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> Length of stay in lb <u>39 yrs</u></p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Mary Hosp</u> Side Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Mo</u> b. COUNTY <u>Jackson</u></p> <p>c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>4204 Clark</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>
<p>3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>J</u> Last <u>Healy</u></p>	
<p>4. DATE OF DEATH Month <u>8</u> - Day <u>10</u> - Year <u>'62</u></p>	
<p>5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> 8. DATE OF BIRTH <u>Dec 28, 1904</u> 9. AGE (last birthday) <u>57</u></p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> 11. BIRTHPLACE (City and state or country) <u>Ross Common, Indiana, U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u></p>	
<p>13a. FATHER'S NAME <u>Thomas Rogerson</u> 13b. MOTHER'S MAIDEN NAME <u>Katherine Hannon</u> 14. NAME OF HUSBAND OR WIFE <u>Michael Healy</u></p>	
<p>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>None</u> 17. INFORMANT Address <u>Michael Healy, 4204 Clark</u></p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Cerebral Vascular Thrombosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u></p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.</p> <p>DUE TO (b) <u>myocardial infarction and mural thrombosis</u> <u>12 days</u></p> <p>DUE TO (c) <u>Coronary Artery Sclerosis and Thrombosis</u> <u>3 years</u></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diffuse Atherosclerosis and Arterial Hypertension</u></p> <p>PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown</p>	
<p>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.)</p>	
<p>20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m.</p>	
<p>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 _____ COUNTY _____ STATE _____</p>	
<p>21. I attended the deceased from <u>1-14-1959</u> to <u>8-10-1962</u> and last saw her <u>alive</u> on <u>8-10-62</u> Death occurred at <u>10:30</u> m on the date stated above, and to the best of my knowledge, from the causes stated.</p>	
<p>22a. SIGNATURE (Degree or title) <u>Graham Asher M.D.</u> 22b. ADDRESS <u>1220 Professional Bldg, Kansas City 6-200</u> 22c. DATE SIGNED <u>8-10-62</u></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE <u>8-13-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u> 23d. LOCATION (City, town, or county) <u>K.C., Mo</u> (State)</p>	
<p>24. FUNERAL DIRECTOR <u>Melody McElley-Eylan</u> ADDRESS <u>MAIN ST.</u> 25. DATE RECD. BY LOCAL REG. <u>8-13-62</u> 26. REGISTRAR'S SIGNATURE <u>Ruth Long</u></p>	

USE BLACK INK OR TYPEWRITER RIBBON

Dr. H. Acher
Prof Bly

Signed

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 Hal Bambergh

Licensed Embalmer No. 3408

P. O. Address Indep, 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.