

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-039795**  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5350

**FILED OCT 21 1963**

|   |   |   |  |   |  |
|---|---|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>JACKSON</b>   |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b> |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>KANSAS CITY</b>   |   | Length of stay in 1b<br><b>30 days</b>  | c. CITY OR TOWN <b>GRANDVIEW</b>   |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>V A HOSPITAL</b>  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  | d. STREET ADDRESS (If outside, give location)<br><b>1412 - 133RD</b>   |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>DONALD</b> Middle <b>J</b> Last <b>BRENNAN</b>  |   |   | 4. DATE OF DEATH<br>Month <b>October</b> Day <b>2</b> Year <b>1963</b>   |   |  |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b>   | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <b>8-23-10</b>  | 9. AGE (last birthday) <b>53</b>  | IF UNDER 1 YEAR IF UNDER 24 HR<br>Months Days Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Cook</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (City and state or country)<br><b>Syracuse, New York</b>  |   | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>   |
| 13a. FATHER'S NAME<br><b>Patrick Brennan</b>  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Catherine Perkins</b>   |  | 14. NAME OF HUSBAND OR WIFE<br><b>Emmett A. Brennan, brother Syracuse, N.Y.</b> |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>Yes WWII</b>   |   | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><b>Emmett A. Brennan, brother Syracuse, N.Y.</b>               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line)<br>PART I. DEATH WAS CAUSED BY:  |   |   |  |   | INTERVAL BETWEEN ONSET AND DEATH   |
| IMMEDIATE CAUSE (a) <b>Myocardial infarction</b>  |   |   |  |   |  |
| DUE TO (b) <b>Coronary thrombosis</b>   |   |   |  |   |  |
| DUE TO (c) <b>Multiple small infarctions of lungs, spleen and kidneys</b>   |   |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Obesity, exogenous, marked</b>  |   |   |  |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input 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<br>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. Attended the deceased from <b>September 10, 1963</b> to <b>October 2, 1963</b><br>Death occurred at <b>12:45</b> <b>8</b> a.m. on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |  |   |  |
| 22a. SIGNATURE (Degree or title)<br><b>Stephen Parks M.D.</b>   |   |   | 22b. ADDRESS<br><b>VA Hospital, Kansas City, Mo.</b>   |   | 22c. DATE SIGNED<br><b>10-2-63</b>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE<br><b>10-5-1963</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Agnes Cemetery</b>   |  | 23d. LOCATION (City, town, or county)<br><b>Syracuse, New York</b>              |  |
| 24. FUNERAL DIRECTOR<br><b>Melody-McGilley-Eylar Funeral Home</b><br><b>1800 E. Linwood, Kansas City, Mo.</b>   |   |   | 25. DATE RECD. BY LOCAL REG.<br><b>10-3-63</b>   | 26. REGISTRAR'S SIGNATURE<br><b>Beaie Smith</b>                                 |  |

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DATE AMENDED

VS 300 Rev. 4/59

1

2 **7806**

3

4 **0**

5 **3**

6

7 **1**

8 **1**

9 **465x**

10

11

12 **76-1**

13

**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 \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.