

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

Registration District No. **199**

Primary Registration District No. **1002**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Jackson**

(b) City or town **Kansas City Mo.**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **Katz Drug Store, 40th & Main**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **X**  
(Specify whether)

In this community **Life**  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**

(c) City or town **Kansas City** **48**  
(If outside city or town limits, write "RURAL")

(d) Street No. **3412 Wyandotte** **3**  
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No) **0**

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Mrs. Mary Agnes O'Neal**

3. (b) If veteran, name war **XX**

(c) Social Security No. **486-05-4942**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **IV** / **9** / **48**  
year \_\_\_\_\_ hour **3** minute **15 P.** M.

21. I hereby certify that I attended the deceased from **IV/1/48** to **IV/9/48**, 19\_\_\_\_; that I last saw her alive on **IV/1/48**, 19\_\_\_\_; and that death occurred on the date and hour stated above.

4. Sex **Female**

5. Color, or race **wh**

6. (a) Single, widowed, married, divorced **divorced**

6. (b) Name of husband or wife **unknown**

6. (c) Age of husband or wife if alive **17** years

7. Birth date of deceased **June 17 1904**  
(Month) (Day) (Year)

Immediate cause of death **Embolic**

Due to **Mitral insufficiency**

Due to **Rheumatic heart**

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

8. AGE: Years **43** Months **9** Days **22** hr. \_\_\_\_\_ min. \_\_\_\_\_  
If less than one day

9. Birthplace **Kansas City Mo**  
(City, town, or county) (State or foreign country)

Major findings: **92.5**

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

10. Usual occupation **Operator**

11. Industry or business **Chase Bag Co.**

12. Name **John B. Fields**

13. Birthplace **Sedalia Mo.**  
(City, town, or county) (State or foreign country)

14. Maiden name **Nellie Riley**

15. Birthplace **Kansas City Mo.**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Nellie Riley**

(b) Address **3412 Wyandotte**

17. (a) **Burial** (b) Date thereof **4-10-48**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Mary**

18. (a) Signature of funeral director **J. W. Wagner**

(b) Address **Kansas City Mo**

19. (a) **4-9-48** (b) **Sheddah Holmes**  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work \_\_\_\_\_  
(Specify type of place) (Means of injury)

23. Signature **J. R. Whisman** (M. D. or other) \_\_\_\_\_  
Address **1310 Bryant Bldg.** Date signed **4-9-48**

**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed Alvin R. Harnsckilo  
Licensed Embalmer No. 4159  
P. O. Address Kansas City 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 this body is not embalmed, fact should be so stated above.**