

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31816

State File No.

4234

BIRTH NO. 42435 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
d. FULL NAME OF HOSPITAL OR INSTITUTION Trinity Luthern Hosp.		d. STREET ADDRESS (If rural, give location) 350 E. Armour Blvd.	

3. NAME OF DECEASED (Type or Print) a. (First) Timothy b. (Middle) Michael c. (Last) QUINLAN			4. DATE OF DEATH (Month) (Day) (Year) Sept. 24, 1952			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH June 24, 1952	9. AGE (In years last birthday) 0	IF UNDER 1 YEAR 3 Months 0 Days	IF UNDER 24 HRS. 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (Infant)		10b. KIND OF BUSINESS OR INDUSTRY (Infant)		11. BIRTHPLACE (State or foreign country) Kansas City, Mo.		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME James M. Quinlan		13b. MOTHER'S MAIDEN NAME Patrica Redl		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Jas. M. Quinlan, 350^E Armour, K.C., Mo. ADDRESS	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cystrophy of Bladder		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Cystrophy	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR

22. I hereby certify that I attended the deceased from Beach, 10, to 24 Sept, 1952, that I last saw the deceased alive on 24 Sept, 1952, and that death occurred at 1:05 m., from the causes and on the date stated above.

23a. SIGNATURE H. E. Carlson M.D. (Degree or title) MD		23b. ADDRESS Professional Bldg		23c. DATE SIGNED 25 Sept 1952
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9-25-52	24c. NAME OF CEMETERY OR CREMATORY Calvary Cem.	24d. LOCATION (City, town, or county) (State) K.C., Mo.	

DATE REC'D BY LOCAL REG. 9-27-52	REGISTRAR'S SIGNATURE Sheraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE Hellody-McGilley-Eylar, K.C., Mo. ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

working under my personal supervision.

Student Embalmer No.....

Signed..... *Glen E. Heck*

Signed.....
Student Embalmer

Licensed Embalmer No. *4063*

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.