

No. 300  
10.48

FILED SEP 7 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

26424

State File No. \_\_\_\_\_

3719

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

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City</b>		c. CITY OR TOWN <b>Kansas City</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>Since 1900</b>		STREET ADDRESS (If rural, give location) <b>75 5345 Tracy</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Mary's Hospital</b>			

3. NAME OF DECEASED (Type or Print) <b>DR. THOMAS</b>	a. (First) <b>E.</b>	b. (Middle) <b>PURCELL</b>	c. (Last) <b>SR.</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Aug. 22 1955</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed 2</b>	8. DATE OF BIRTH <b>Nov. 14th, 1873</b>	9. AGE (In years last birthday) <b>81</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Dentist</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Chicago, Illinois</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>
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13a. FATHER'S NAME <b>James M. Purcell</b>	13b. MOTHER'S MAIDEN NAME <b>Johanna Brazil</b>	14. NAME OF HUSBAND OR WIFE <b>May E. Purcell</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>No</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Dr. T. E. Purcell, Jr.</b>	ADDRESS <b>5325 Rookhill Rd.</b>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Arteriosclerotic Heart Disease</b>		
	II. OTHER SIGNIFICANT CONDITIONS <b>Benign Prostatic Hypertrophy</b>		
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a), stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____			

19a. DATE OF OPERATION <b>8/18</b>	19b. MAJOR FINDINGS OF OPERATION <b>Giant prostatic adenoma.</b>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (eg., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 8-15, 1955, to 8/22, 1955, that I last saw the deceased alive on 8-21, 1955, and that death occurred at 5:45 A.M., from the causes and on the date stated above.

23a. SIGNATURE <b>Robert H. Owens</b> (Degree or title) <b>M.D.</b>	23b. ADDRESS <b>628 Professional Bldg</b>	23c. DATE SIGNED <b>8/22/55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>8-23-55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's</b>	24d. LOCATION (City, town, or county) (State) <b>Kansas City Missouri</b>
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DATE REC'D BY LOCAL REG. <b>8-23-55</b>	REGISTRAR'S SIGNATURE <b>Heva Marshall</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Melody-MoGilly-Bylar</b>	ADDRESS <b>1800 Linwood</b>
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(Licensed Embalmer's Statement on Reverse Side)

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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....  


Licensed Embalmer No. 2999

P. O. Address..... K.

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.