Health, Welfare Public Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

W. M. Ketcham

FILED NOV 28 1956

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

38163
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4718

1. PLACE OF DEATH
a. COUNTY JACKSON
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN KANSAS CITY — Inside Limits Yes ☒ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) ST. JOSEPH — Length of stay in 18 30 YRS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY JACKSON
c. CITY OR TOWN KANSAS CITY — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 2119 E 67th TERR — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First WILLIAM Middle J. Last MOONEY

4. DATE OF DEATH Month OCT Day 30 Year 1956

5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH JULY 26, 1895
9. AGE (In years last birthday) 61 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINT. ENG.
10b. KIND OF BUSINESS OR INDUSTRY FARM EQUIP. JOHN DEERE
11. BIRTHPLACE (City and state or country) BUFFALO, N.Y.
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME WILLIAM MOONEY
14. MOTHER'S MAIDEN NAME KATHERINE DWYER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW 1
16. SOCIAL SECURITY NO. 500-20-9507
17. INFORMANT Address MRS. BLANCHE MOONEY 2119 E. 67th Ter.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sub-Arachnoid Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 5 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Small aneurysm — years
DUE TO (c) — 330X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from October 26-56 to October 30-56 and last saw him alive on October 30 56
Death occurred at 4:40 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) W M Ketcham MD.
22b. ADDRESS KC Mo
22c. DATE SIGNED 11-1-56

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE NOV 3, 1956
23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET
23d. LOCATION (City, town, or county) (State) KANSAS CITY, MO.

24. FUNERAL DIRECTOR ADDRESS MUEHLEBACH 6800 TROOST
25. DATE RECD. BY LOCAL REG. 11-1-56
26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Thomas A. Kaehl

Licensed Embalmer No. 49

P. O. Address K.C., T

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (
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.