

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER  
36041  
4621

FILED OCT 24 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4621

S. 300  
v. 1-57

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, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Menorah Medical Center			Length of stay in 1b 60 yrs		d. STREET ADDRESS 4201 Montgall		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Fred O'connor				4. DATE OF DEATH Month Day Year 10 5 57								
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 2-3-88		9. AGE (In years last birthday) 69		10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk, Retired			10b. KIND OF BUSINESS OR INDUSTRY Milgram Store Inc.		11. BIRTHPLACE (City and state or country) Elk City, Kansas			12. CITIZEN OF WHAT COUNTRY? USA				
13a. FATHER'S NAME Thomas O'Conner			13b. MOTHER'S MAIDEN NAME Louise Owen			14. NAME OF HUSBAND OR WIFE Blanche O'Conner						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 512-20-7949		17. INFORMANT Mrs. Myrtle Quinn		Address 4201 Montgall				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decom pensation</u>								INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)		DUE TO (c) <u>COR Pulmonate pulmonary fibrosis chronic bronchitis</u>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 5021								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 Hour Month, Day, Year a.m. p.m.												
20d. INJURY OCCURRED WHILE AT <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. I attended the deceased from <u>9-16-57</u> to <u>10-5-57</u> and last saw her alive on <u>10-4-57</u> Death occurred at <u>7:45 AM.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.												
22a. SIGNATURE (Degree or title) <u>David Waxman M.D.</u>						22b. ADDRESS <u>4240 project</u>			22c. DATE SIGNED <u>10-5-57</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>October 8, 1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Moriah</u>			23d. LOCATION (City, town, or county) <u>Kansas City</u>			STATE <u>Mo</u>		
24. FUNERAL DIRECTOR <u>Melody-McGilley-Eylar</u>				ADDRESS <u>Kansas City</u>		25. DATE RECD. BY LOCAL REG. <u>10-5-57</u>		26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>				

(License of Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
 MEDICAL CERTIFICATION  
 David Waxman

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mm - 0600

STATEMENT BY LICENSED EMBALMER

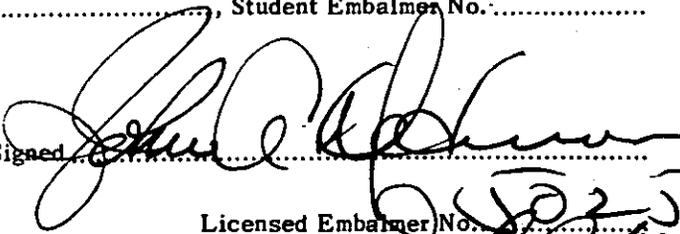
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed

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.