

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40348

STATE FILE NUMBER

FILED DEC 2 - 1957

Registration District No. 149 Primary Registration District No. 1002

Registrar's No. 5235

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
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Marys Hospital		Length of stay in lb 45 yrs*	d. STREET ADDRESS (If outside, give location) 7400 Highland
3. NAME OF DECEASED (Type or print) First WILLIAM Middle JOSEPH Last GLYNN			4. DATE OF DEATH Month NOVEMBER Day 6 Year 1957
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 type="checkbox"/>	8. DATE OF BIRTH Sept. 20, 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Tax Employee		10b. KIND OF BUSINESS OR INDUSTRY Mo. Dept of Revenue	9. AGE (In years last birthday) 67
11. BIRTHPLACE (City and state or country) Keokuk, Iowa		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Thomas Glynn		13b. MOTHER'S MAIDEN NAME Anna Coyle	14. NAME OF HUSBAND OR WIFE Catherine Elizabeth Glynn
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES W.W. #1		16. SOCIAL SECURITY NO. 486-26-3114	17. INFORMANT Mrs. Catherine Elizabeth Glynn Address 7400 Highland
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>Mitotic Carcinoma of Lung.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Pneumonia Carcinoma of Colon</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 7 1955 153x
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input checked="" type="checkbox"/> <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 _____ p.m. _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>11/5/57</u> to <u>11/6/57</u> and last saw her alive on <u>11/6/57</u> Death occurred at <u>5:45 P.m.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>C. G. Leitch M.D.</u> (Degree or title) <u>D</u>		22b. ADDRESS <u>1010 Pmg Bldg Keokuk</u>	
22c. DATE SIGNED <u>11/8/57</u>		22d. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11/9/57	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) Kansas City, Missouri
24. FUNERAL DIRECTOR QUIRK & TOBIN-20 W. Linwood, K.C. Mo.		25. DATE RECD. BY LOCAL REG. 11-8-57	26. REGISTRAR'S SIGNATURE <u>Neve Marshall</u>

securing the medical certification in the specific manner required by 193.140 MoRS 1947.
 All diseases in Part I must be causally related.
 No symptoms will be listed.
 No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION
 C. G. Leitch



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 *E. A. Gibson*

Licensed Embalmer No. *4137*
P. O. Address *100 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.