

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-014100
STATE FILE NUMBER
1730

FILED APR 23 1958

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

300
1-57

| | | | | | | | |
|--|----------------------------------|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Jackson</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN <u>KANSAS CITY</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>6215 E. 16th ST.</u> | | Length of stay in lb <u>Life 30</u> | | d. STREET ADDRESS (If outside, give location) <u>6215 E. 16th ST.</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>J.</u> Last <u>Burnell</u> | | | | 4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>1958</u> | | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>CAUC.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>July 13, 1887</u> | | 9. AGE (In years last birthday) <u>70</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>BRASS COMPANY</u> | | 11. BIRTHPLACE (City and state or country) <u>KANSAS CITY, MISSOURI</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>BURNELL</u> | | 13b. MOTHER'S MAIDEN NAME <u>ANN WALSH</u> | | 14. NAME OF HUSBAND OR WIFE <u>Josephine BURNELL</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>487-03-1512</u> | | 17. INFORMANT Address <u>MR. Joseph Burnell 1235 SO. HARDY</u> | | | |
| 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>Intestinal obstruction</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Carcinoma of the bowel (colon)</u> | | | | | | <u>1538</u> | |
| DUE TO (c) <u>Myocarditis with cardiac decompensation</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | | | |
| 20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input 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 o.m. p.m. | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <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>March 19, 1958</u> to <u>April 3, 1958</u> and last saw ^{her} him alive on <u>April 2, 1958</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>Ralph Perry M.D.</u> | | | | 22b. ADDRESS <u>4800 E. 24th Street</u> | | 22c. DATE SIGNED <u>4-4-58</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Partial</u> | | 23b. DATE <u>April 5, 1958</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY Missouri</u> | | |
| 24. FUNERAL DIRECTOR <u>Muehlebach</u> ADDRESS <u>6800 TROST</u> | | | 25. DATE RECD. BY LOCAL REG. <u>4-4-58</u> | | 26. REGISTRAR'S SIGNATURE <u>Irene Marshall</u> | | |

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Ralph Perry

Dr. R. Perry
4850 E. 2nd
1:00 P.M.

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 R. L. Nichols

Licensed Embalmer No. 4997

P. O. Address K. C. 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.