

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-032896  
STATE FILE NUMBER

FILED SEP 24 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4187

S. 300  
1-57

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, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If <del>deceased</del> in hospital/home) HOSPITAL OR INSTITUTION <b>3918 Charlotte St.</b>		Length of stay in lb <b>11 Years</b>	d. STREET ADDRESS (If outside, give location) <b>421 West 62nd Street</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>MATILDE</b> Middle Last <b>O'LEARY</b>			4. DATE OF DEATH Month <b>August</b> Day <b>31</b> Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 21, 1875</b>
9. AGE (In years last birthday) <b>82</b>		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) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	11. BIRTHPLACE (City and state or country) <b>Mount Vernon, Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13a. FATHER'S NAME <b>MARTIN HENRICHS</b>	
13b. MOTHER'S MAIDEN NAME <b>BERTHA</b>		14. NAME OF HUSBAND OR WIFE <b>R. D. O'Leary</b>	
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>None</b>	17. INFORMANT Address <b>Theodore M. O'Leary, 5624 Buena Vista</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic Cardiovascular disease</b>			<b>24 hrs. dys.</b>
DUE TO (c) <b>—</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Hypertension</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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.) <b>—</b>	
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.) <b>—</b>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <b>—</b>	
21. I attended the deceased from <b>Aug 30, 1958</b> , to <b>Aug 31, 1958</b> and last saw her/him alive on <b>Aug 31, 1958</b> Death occurred at <b>3:15 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>William F. Sanders M.D.</b> (Dee or title)		22b. ADDRESS <b>411 Nicholas Rd. K.C. Mo</b>	
22c. DATE SIGNED <b>Sept 2, 1958</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE <b>Sept. 3, 1958</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>D. W. Newcomer's Sons</b>		23d. LOCATION (City, town, or county) (State) <b>Kansas City Missouri</b>	
24. FUNERAL DIRECTOR <b>D.W. Newcomer's Sons Kansas City, Mo.</b> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>9-2-58</b>	
		26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>	

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION



DEC 22 1958

DEC 23 1958

DEC 23 1958

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 *Albert L. Savage* .....

Licensed Embalmer No. *4872* .....  
P. O. Address *Kansas City* .....

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.