

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017634

STATE FILE NUMBER
2449

JUN 9 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Missouri b. COUNTY Saline	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Shackleford	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph's Hosp.		d. STREET ADDRESS 26 days	

3. NAME OF DECEASED (Type or print) First Middle Last Rev. Father JAMES J. BURNS			4. DATE OF DEATH Month Day Year May 17 1959		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2, 1890	9. AGE (In years last birthday) 68	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pastor Emmeritus	10b. KIND OF BUSINESS OR INDUSTRY Catholic Priest	11. BIRTHPLACE (City and state or country) Stockton, Pennsylvania	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME unknown	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE None
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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. No	17. INFORMANT Melody-Mc Gilley-Eylar Address Kansas City, Mo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia lobar		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) Congestive Heart Failure		
DUE TO (c) Cor Pulmonalis		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cerebral Edema		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 **Nov. 1956** to **May 17th 1959** and last saw ^{her}him alive on **May 17 1959**
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Paul A. G. Johnson (Degree or title) MD	22b. ADDRESS 5111 Luley Ave	22c. DATE SIGNED 5/18/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5-20-1959	23c. NAME OF CEMETERY OR CREMATORY mt. St-mary	23d. LOCATION (City, town, or county) (State) Shackleford, Mo.
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24. FUNERAL DIRECTOR Melody-McGilley-Eylar Funeral Home ADDRESS Woodland-Linwood	25. DATE RECD. OF LOCAL REG. 5-18-59	26. REGISTRAR'S SIGNATURE Neva Marshall
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

300
1-57

Paul A. G. Johnson

JUL 29 1958

P. A. G. Johnson

Call me at

WA 1-17717

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 James W. Wain

Licensed Embalmer No. 4650

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.