

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 7 1959

59-040001

STATE FILE NUMBER

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 5631

5631

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|---|--|---|--|--|--|--|--|--|--|
| 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 | | Length of stay in 1b 70 years | | 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 Little Sisters of the Poor | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 5331 HIGHLAND | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last CECILIA CURRAN | | | | 4. DATE OF DEATH Month Day Year NOVEMBER 21, 1959 | | | | | |
| 5. SEX FEMALE | 6. COLOR OR RACE CAUC. | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH May 2, 1874 | | 9. AGE (last birthday) 85 | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRACTICAL NURSE | | | 10b. KIND OF BUSINESS OR INDUSTRY NURSING | | 11. BIRTHPLACE (City and state or country) CHILLOCOTHE, MA | | 12. CITIZEN OF WHAT COUNTRY U. S. A. | | |
| 13a. FATHER'S NAME PATRICK CURRAN | | | 13b. MOTHER'S MAIDEN NAME UNKNOWN | | | 14. NAME OF HUSBAND OR WIFE NONE | | | |
| 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. None | | 17. INFORMANT MISS CECILIA STECK | | | Address 5109 TRACY | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia (Hypostatic) DUE TO (b) Arteriosclerosis DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 days 20 hrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | |
| 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 a.m. p.m. | Month, Day, Year | | | | | | | | |
| 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 3/19/50 , to 11/21/59 and last saw her ^{her} alive on 11/20/59 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) Joseph A. Fogarty | | | | 22b. ADDRESS 402 Northern Bldg 610 Mo | | 22c. DATE SIGNED 11/22/59 | | | |
| 23a. BURIAL, CREATION, REMOVAL (Specify) BURIAL | | 23b. DATE Nov. 23, 1959 | 23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY | | 23d. LOCATION (City, town, or county) (State) KANSAS CITY MISSOURI | | | | |
| 24. FUNERAL DIRECTOR MUEHLEBACH | | | ADDRESS 8800 TROOST. | | 25. DATE RECD. BY LOCAL REG. 11-22-59 | | 26. REGISTRAR'S SIGNATURE Neva Minchall | | |

DOCUMENT

BY AFFIDAVIT OF Joseph A. Fogarty MEDICAL CERTIFICATION

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 B. E. Nichol

Licensed Embalmer No. 4887

P. O. Address H. 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.