

21 DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
 FILED VS APR 25 1960

-60-015524

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1845 STATE FILE NUMBER

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 MO</u>		c. CITY OR TOWN <u>Kansas City MO</u>	
Length of stay in 1b <u>62 yrs</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>Nora Rae Restorium</u>		d. STREET ADDRESS (If outside, give location) <u>3311 Spruce</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Thomas</u> Last <u>Moran</u>			4. DATE OF DEATH Month <u>3</u> Day <u>29</u> Year <u>1960</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>May 24, 1870</u>	9. AGE (last birthday) <u>89</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dentist</u>		11. BIRTHPLACE (City and state or country) <u>Chicago, Ill.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>Thomas Riley Moran</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Riley</u>	
14. NAME OF HUSBAND OR WIFE <u>Jane T. Moran</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Lucille Reinecke</u>		Address <u>Colorado Springs, Colo.</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>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arterio sclerosis</u>		<u>6 years</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)		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 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 2-18-60 to 3-29-60 and last saw her/him alive on 3-29-60
 Death occurred at 428 S White Ave on the date stated above, and to the best of my knowledge, from the causes stated.

22. SIGNATURE (Degree or title) <u>Frank Paul Laureyana M.D.</u>		22b. ADDRESS <u>428 S White Ave</u>	22c. DATE SIGNED <u>3-29-60</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23a. DATE <u>4-1-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Elmwood</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>
24. FUNERAL DIRECTOR <u>France Wornall Funeral Home</u>		25. DATE RECD. BY LOCAL REG. <u>3-30-60</u>	26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT
 Laureyana
 MEDICAL CERTIFICATION
 Paul
 BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by James C. Anderson, Student Embalmer No. 597
working under my personal supervision.

Student James C. Anderson
Signature of Student Embalmer

Signed Russell N. Fran

Licensed Embalmer No. 425

P. O. Address K. C. 7

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.