

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-017412

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

REVISED MAY 29 1961 AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2358

STATE FILE NUMBER

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF S. Bourke

1. PLACE OF DEATH a. COUNTY <u>Jackson</u> b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u> Length of stay in 1b <u>Life</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Our Lady of Mercy Home</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>9th. & Charlotte</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>MISS JULIA</u> Middle <u>C.</u> Last <u>DWYER</u>			4. DATE OF DEATH Month <u>May</u> Day <u>12</u> Year <u>1961</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-12-1868</u>	9. AGE (last birthday) IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HR: Hours <u> </u> Min. <u> </u>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>employee</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Rich-Con Hdwe Co.</u>		11. BIRTHPLACE (City and state or country) <u>Kansas City, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Edward Dwyer</u>		13b. MOTHER'S MAIDEN NAME <u>Ellen Spillane</u>		14. NAME OF HUSBAND OR WIFE <u> - - - - -</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>			17. INFORMANT Address <u>Mrs. Josephine Spillane-- 5129 Forest</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>Terminal Bronchial Pneumonia</u> DUE TO (b) <u>Infection?</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
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 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 <u> </u> a.m. <u> </u> p.m. Month, Day, Year <u> </u>		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>for part of months</u> to <u>5-12-61</u> and last saw her/him alive on <u>5-11-61</u> Death occurred at <u> </u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>S. Bourke, MD</u>			22b. ADDRESS <u>200 Reids H.C. MO.</u>		22c. DATE SIGNED <u>5-12-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5-15-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. St. Mary's</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Melody-McGilley-Eylar--1800 E. Linwood</u>			25. DATE RECD. BY LOCAL REG. <u>5-12-61</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>	

Dr. J.S.
200 Rice

U12-3345

Sun.
Home - 9:30 A.M.
St. Mary's Hosp. - 10

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 E. Kachler

Licensed Embalmer No. 4572

P. O. Address A. C. 7th

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.