

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-006777

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 952

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED FEB 20 1963

| | | | | | | |
|------------------------------------|--------------|--|--|----------|-----------------------|-----------------|
| VS 300 Rev. 4/59 | DATE AMENDED | | AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF | DOCUMENT | MEDICAL CERTIFICATION | BY AFFIDAVIT OF |
| 1 | | | | | | |
| 2 <u>3518</u> | | | | | | |
| 3 | | | | | | |
| 4 <u>0</u> | | | | | | |
| 5 <u>0</u> | | | | | | |
| 6 | | | | | | |
| 7 <u>0</u> | | | | | | |
| 8 <u>0</u> | | | | | | |
| <u>9490X</u> | | | | | | |
| 10 | | | | | | |
| 11 | | | | | | |
| 12 <u>86-0</u> | | | | | | |
| 13 | | | | | | |
| USE BLACK INK OR TYPEWRITER RIBBON | SHOULD READ | | | | | |

| | | | |
|--|---|---|--|
| 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</u> | | Length of stay in 1b <u>50 yrs.</u> | c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF HOSPITAL OR INSTITUTION <u>New Hope Nursing Home</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>101 E. 36th. St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>MAURICE W. MC DONNELL</u> | | | 4. DATE OF DEATH Month Day Year <u>February 12, 1963</u> |
| 5. SEX <u>Male</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>3-27-1888</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Bendix Aviation</u> | 9. AGE (last birthday) <u>74</u> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. |
| 11. BIRTHPLACE (City and state or country) <u>Holden, Missouri</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>Patrick J. McDonnell</u> | | 13b. MOTHER'S MAIDEN NAME <u>Johanna Leahy</u> | |
| 14. NAME OF HUSBAND OR WIFE <u>none</u> | | 17. INFORMANT Address <u>Mrs. Florence M. Waters 3220 Karnes</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> | | 16. SOCIAL SECURITY NO. <u>[REDACTED]</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, Acute</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Upper Respiratory Infection</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 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>1-2-63</u> to <u>2-11-63</u> and last saw ^{her} him alive on <u>2-11-63</u> Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Dee or title) <u>Otto H. Theel M.D.</u> | | 22b. ADDRESS <u>4301 Main St. KC Mo</u> | 22c. DATE SIGNED <u>2-12-63</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>2-13-63</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Marys</u> | 23d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u> |
| 24. FUNERAL DIRECTOR <u>Melody-McGilley-Eylar</u> | | 25. DATE RECD. BY LOCAL REG. <u>2-12-63</u> | 26. REGISTRAR'S SIGNATURE <u>[Signature]</u> |

Mr. O. H. Steel
4301 Main

Ke 1-3199

Tues: 1:30 to 5:00

STATEMENT BY LICENSED EMBALMER

0-58

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 Floyd F. Dickmon

Licensed Embalmer No. 5120

P. O. Address Ke 11, 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.