

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-032197
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4639

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 11 1963

VS 300	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS	INSTEAD OF	DOCUMENT
Rev. 4/59				
1				
2 3718				
3				
4 0				
5 1				
6				
7 0				
8 2				
9 451X				
10				
11				
12 65-0				
13				
ITEM NO.		SHOULD READ		
BY AFFIDAVIT OF		MEDICAL CERTIFICATION		

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Jackson</u>		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>		c. CITY OR TOWN <u>Kansas City</u>	
Length of stay in 1b <u>life</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>St. Joseph Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>4518 Wyoming</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>JOHN</u> Middle <u>F</u> Last <u>CRONIN, SR.</u>			4. DATE OF DEATH Month <u>August</u> Day <u>20</u> Year <u>1963</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-17-1893</u>
9. AGE (last birthday) <u>70</u>	IF UNDER 1 YEAR		IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>K.C. Fire Dept.</u>	11. BIRTHPLACE (City and state or country) <u>Kansas City, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Patrick Cronin</u>		13b. MOTHER'S MAIDEN NAME <u>Mary O'Leary</u>	
14. NAME OF HUSBAND OR WIFE <u>Pauline Cronin</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>		17. INFORMANT Address <u>Robert E. Cronin 6121 W. 54th. Mission, Ks.</u>	
18. CAUSE OF DEATH (Enter only one cause per line -PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cardiovascular</u>			<u>3 days</u>
DUE TO (b) <u>arteriosclerotic heart & kidney disease</u>			<u>1 year</u>
DUE TO (c) <u>abdominal aortic aneurysm</u>			<u>1 1/2 years</u>
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 checked="" 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 <u>[redacted]</u> s.m. <u>[redacted]</u> p.m. <u>[redacted]</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>7-15-63</u> to <u>8-20-63</u> and last saw her alive on <u>8-20-63</u>		Death occurred at <u>3:30 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>John T. Skinner MD</u>		22b. ADDRESS <u>1102 Grand St. PMO</u>	22c. DATE SIGNED <u>8-21-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-23-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Melody-McGilley-Eylar 20 W. Linwood</u>		25. DATE RECD. BY LOCAL REG. <u>8-21-63</u>	26. REGISTRAR'S SIGNATURE <u>Bessie Smith</u>

(Licensed Embalmer's Statement on Reverse Side)

Dr. J. T. Skinner
Bryant Blvd.
4-2-7010

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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 Lloyd Duckman

Licensed Embalmer No. 5120

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.