

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

15142

1. PLACE OF DEATH

County Jackson
Township Staw
City Kansas City (No. Grace Joseph)

Registration District No. 399
Primary Registration District No. 1002

File No. _____
Registered No. 5 2000
St. _____ Ward _____

2. FULL NAME

Patricia Rose Shanahan

(a) Residence No. 2403 C. 23rd St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 9, 1927

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 6 160 53 1,570

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Kansas City, Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER Thomas Shanahan

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Kansas City, Mo.
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Vida Maxwell

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
(STATE OR COUNTRY)

14. INFORMANT Thos. Shanahan
(Address) 2403 C. 23rd St.

15. FILED May 16, 27 M. M. Brown REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 15 1927

17. I HEREBY CERTIFY, That I attended deceased from May 7th, 1927, to 15th, 1927, that I last saw her alive on May 15, 30 P, 1927, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Foramen Ovale failed to properly close
159 B (duration) yrs. mos. ds. 6

CONTRIBUTORY (SECONDARY) Difficult birth with strangled cord (duration) yrs. mos. ds. _____

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) Chas F. Clark, M. D.
5716, 1927 (Address) 1016 Chambers Bldg.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mt. St. Mary's DATE OF BURIAL May 16 1927

20. UNDERTAKER W. H. Newcomer's Sons ADDRESS R. G. Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS SHOULD STATE

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Hara 0996.

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