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

Do not use this space.

24462

1. PLACE OF DEATH
County Jackson — Registration District No. 399 — File No. [illegible]
Township Kaw — Primary Registration District No. 1002 — Registered No. [illegible]
City Kan. City (No. 3419 Anderson St. Ward)

2. FULL NAME Cornelius E. Hannafen
(a) Residence. No. 3419 Anderson 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: M
4. COLOR OR RACE: Wh
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Hannah
6. DATE OF BIRTH (MONTH, DAY AND YEAR): Jan. 13, 1846
7. AGE: Years 80 — Months 5 — Days 23 — If LESS than 1 day, ___ hrs. or ___ min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ireland

PARENTS
10. NAME OF FATHER: Wm Hannafen
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ireland
12. MAIDEN NAME OF MOTHER: Margaret Lissett
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Ireland

14. INFORMANT: Margaret Hannafen
(Address) 3419 Anderson

15. FILED 8/22, 1927 M. M. Crowe, Asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Aug 20 1927

17. I HEREBY CERTIFY, That I attended deceased from Aug 14, 1927, to Aug 15, 1927, that I last saw him alive on Aug 15, 1927, and that death occurred, on the date stated above, at 11-30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Apoplexy
(duration) yrs. mos. 7 ds.
CONTRIBUTORY (SECONDARY): Arterio Sclerosis
(duration) 2 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? x
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? usual
(Signed) J. L. Robinson, M. D.
8-22, 1927 (Address) 510 Altman Bld

*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 Marys — DATE OF BURIAL: 8/23 1927
20. UNDERTAKER: Lunk & Tobin Co — ADDRESS: 10 W Linwood

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County: Jackson — Registration District No.: 399 — File No.:

Township: — Primary Registration District No.: 1002 — Registered No.: 3250

City: Kan. City (No. ..... St. ..... Ward)

2. FULL NAME Cornelius E. Hannagan

(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)

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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
M	W	M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 13. 1847

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	80	7	7	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT .....
(Address)

15. FILED 8/2 ~, 19 27 M. E. Crowe
Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 20 1927

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19..... that I last saw h..... alive on ..... 19..... and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

..... (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) ....., M. D

, 19 (Address)

*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	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

should state ... very important

AGE should ... classified. ... CCL

careful ... it may

... HALL NOT RECEIVE A F OR ... CATES UNTIL TH ... ARE COMPLETE AS PRESCRIBED BY LAW

... REGIS