

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

Do not use this space.

23187
3224

1. PLACE OF DEATH **Jackson**
 County Registration District No. **399**
 Township **Kaw** Primary Registration District No. **1052**
 City **Kansas City** (No. **5th & May**) St. Ward)

File No.
 Registered No.

2. FULL NAME **Michael O'Rourke**
 (a) Residence. No. **6th & Wyandotte** St. **1** Ward. (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 **Male**
 4. COLOR OR RACE **White**
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Married Divorced**
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Unknown**
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Unknown**
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. **About 56**
 8. OCCUPATION OF DECEASED **Laborer**
 (a) Trade, profession, or particular kind of work **Unemployed**
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer **Unemployed**

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

10. NAME OF FATHER **Michael O'Rourke**
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Ireland**
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER **Ellen O'Rourke**
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Iowa**
 (STATE OR COUNTRY)

14. INFORMANT **Coroner's Record**
 (Address)

15. FILED **8/23/30** 19 **30** **M. M. Crepey** REGISTRAR
asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **7-28 1930**
 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:

Chronic myocarditis
92A
93C
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **Chronic Endocarditis**
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED **POA**
 IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? **No** DATE OF.....
 WAS THERE AN AUTOPSY? **Yes**

WHAT TEST CONFIRMED DIAGNOSIS **Autopsy**
 (Signed) **Stanley W. Hoop** M. D. **7/28** 19 **30** (Address) **Deputy Coroner**

*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 **Maple Hill K.C.Ks.** DATE OF BURIAL **8-5-30** 19

20. UNDERTAKER **R. V. Lindsey & Sons, Inc** ADDRESS **Kans City Mo**

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.

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