

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

Do not use this space.

1614

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

97 Bell
Professional Bldg
Office Hours
Vic 4238
175 W 50th
Val Mason

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

Registration District No. **399**
Township **Rau** Primary Registration District No. **1002**
City **Kansas City** (No. **Research Hospital**) St. **Mo.** Ward **3**
Registered No. **314**

2. FULL NAME **Thomas Kane**
(a) Residence, No. **1650 Bellview** St. **3** 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) **single**
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **unknown**
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. **47**
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **Clerk**
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. **Wm. Vokar**
10. Date deceased last worked at this occupation (month and year) **Nov. Mo.** 11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **K.C. Mo.**
13. NAME **Thomas Kane**
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ireland**
15. MAIDEN NAME **Mary Brennan**
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ireland**
17. INFORMANT (ADDRESS) **Kate Kane 1650 Bellview**
18. BURIAL, CREMATION, OR REMOVAL PLACE **St. Mary's** DATE **1-23** 1935
19. UNDERTAKER (ADDRESS) **Quirk & Tisher**
20. FILED **1-28** 1935 **M. M. Crowe** Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Jan 19** 19**33**
22. I HEREBY CERTIFY, That I attended deceased from **Jan 16** 19**33** to **Jan 19** 19**33**
I last saw him alive on **Jan 19** 19**33** Death is said to have occurred on the date stated above at **6:35 pm.**
The principal cause of death and related causes of importance were as follows:
Pneumonia Date of onset **1/19/33**
Chronic Hypertensive Type
Other contributory causes of importance:
Chronic Hypertensive Type
Name of operation **None** Date of **None**
What test confirmed diagnosis? **Physician's Report** Was there an autopsy? **No**
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury _____
Nature of injury _____
24. Was disease or injury in any way related to occupation of deceased? **No**
If so, specify _____
(Signed) **John V. Bell** M. D.
(Address) **1137 Professional Bldg**

11

11

11

11

11

11