

FEB 19 1935

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

Do not use this space.

1138

1. PLACE OF DEATH

County Jackson

Registration District No. 399

Township Lebanon

Primary Registration District No. 1002

City Kansas City (No. General Hospital)

File No. _____

Registered No. _____

St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 3527 Campbell St. _____ Ward _____
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 2 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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1-3-1872

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>62</u>	<u>11</u>	<u>29</u>	

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas

MOTHER FATHER 13. NAME John Malloy

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

MOTHER 15. MAIDEN NAME Ann Malloy

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

17. INFORMANT (ADDRESS) Richard Clark, K.B. General Hospital

18. BURIAL, CREMATION, OR REMOVAL PLACE Covermouth DATE 1-2-35

19. UNDERTAKER (ADDRESS) O'Donnell and Co.

20. FILED Jan. 1, 1935 M. M. Cronin Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-1-35

22. I HEREBY CERTIFY, That I attended deceased from 12-21-34, 1934, to 1-1-35, 1935

I last saw him alive on 1-1-35, 1935. Death is said to have occurred on the date stated above, at 11:35 a.m.

The principal cause of death and related causes of importance were as follows:

Cerebral Edema
Hydrocephalus

Other contributory causes of importance: 131

Memorial
Chronic Glomerulonephritis

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 1935

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 _____

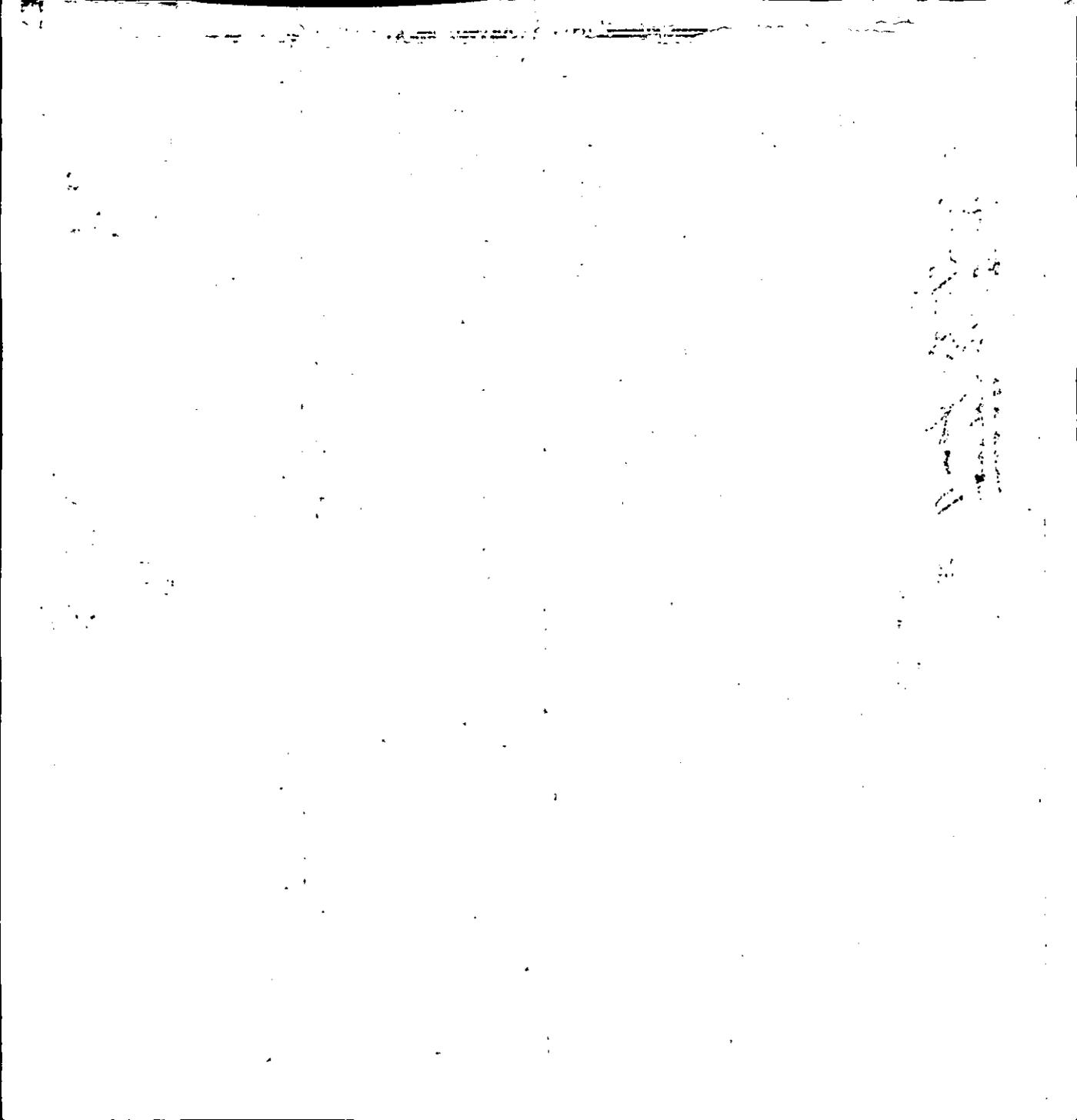
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) J. H. Cronin, M. D.

(Address) Dept. Gen. Hosp.



**MISSOURI STATE BOARD OF HEALTH
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 CERTIFICATE OF DEATH**

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. 1138
 Township _____ Primary Registration District No. 1002 Registered No. 4
 City Kansas City (No. General Hospital St. _____ Ward)

2. FULL NAME Michael Malloy
 (a) Residence, No. _____ 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

MEDICAL CERTIFICATE OF DEATH

3. SEX M **4. COLOR OR RACE** W **5. SINGLE, MARRIED, WIDOWED, OR DIVORCED** M
 (write the word)
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) _____
7. AGE YEARS 62 MONTHS 11 DAYS 2
 If less than 1 day _____ hrs. _____ min.
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ **11. Total time (years) spent in this occupation** _____

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 1, 1935
22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.
 I last saw h_____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:

Cerebral Edema
Hydrocephalus Acquired
(Non tuberculous)
 Other contributory causes of importance Uremia
Chronic Nephritis

Date of onset _____

(12) BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
13. NAME _____
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
15. MAIDEN NAME _____
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____
17. INFORMANT (ADDRESS) _____
18. BURIAL, CREMATION, OR REMOVAL PLACE DATE _____, 19____
19. UNDERTAKER (ADDRESS) _____
20. FILED 1-1-35 M. M. Brown Registrar.

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____
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? _____
 If so, specify _____
 (Signed) J. H. Jennett, M. D.
 (Address) Supt. General Hospital

PRELIMINARY

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