

OCT 19 1937

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

Do not use this space.

1. PLACE OF DEATH

 County Jackson Registration District No. 399
 Township Jean Primary Registration District No. 1002
 City Kansas City (No. 12) Gen Hosp St. _____ Ward _____

 File No. 33458
 Registered No. 3303
 St. _____ Ward _____

2. FULL NAME

 (a) Residence, No. 15 E. 64 St. _____ Ward _____
 (Usual place of abode)

(If nonresident, give city or town and State)

 Length of residence in city or town where death occurred 20 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 w 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) March 19, 1885
 7. AGE YEARS 52 MONTHS 6 DAYS 9 If LESS than 1 day, hrs. or min.

8. Trade, profession, or particular kind of work done, as splinner, sawyer, bookkeeper, etc.

Labourer

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) Mo13. NAME Thomas Hays14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland15. MAIDEN NAME Jennie Flannigan16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland17. INFORMANT (ADDRESS) Reverend Clerk18. BURIAL, CREMATION, OR REMOVAL St. Elizabeth's DATE Sept. 29-3119. UNDERTAKER (ADDRESS) Quick-Fisher20. FILED 9-28 137 M.M. Crowe esch Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-26, 1937

22. I HEREBY CERTIFY, That I attended deceased from

9-7, 1937 to 9-26, 1937I last saw him alive on 9-26, 1937 Death is saidto have occurred on the date stated above, at 3:45 a.m.

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

Carcinoma of sigmoid with metastases to liver Date of onsetOther contributory causes of importance: 46

Name of operation _____ Date of _____

What test confirmed diagnosis? Autopsy 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 _____, 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) P. D. De Marco, M. D.(Address) St. Elizabeth's Hosp 72C

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