

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

34723

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. _____
 (b) Township Kaw Primary Registration District No. _____ Registered No. 4059
 (c) City Kansas City (d) Street No. 4143 Campbell St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Michael J. Halleran
 (a) Residence, No. 4143 Campbell St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Divorced
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Unknown
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan. 6, 1878
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 60 9 10

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 16, 1938
 22. I HEREBY CERTIFY, That I attended deceased from July 7, 1935 to Oct. 16, 1938
 I last saw him alive on Oct. 6, 1938 Death is said to have occurred on the date stated above, at 10 P. m.
 The principal cause of death and related causes of importance were as follows:

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

leanna of stomach. Diagnosis made at veterans hospital in Geleson Springs, by operation
 Date of onset 46 1/2

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Centertown, Missouri

Other contributory causes of importance: _____

FATHER 13. NAME Michael J. Halleran

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? no

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

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. home

MOTHER 15. MAIDEN NAME Elizabeth Conlon

Manner of injury _____
 Nature of injury _____

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

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____
 (Signed) J. M. Frankenburg, M. D.
 (Address) 874 Broad St.

17. INFORMANT (ADDRESS) Miss Margaret Halleran
4143 Campbell

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Marys DATE 10/19/38

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Quirk & Tobin Co.
Kansas City, Mo.

20. FILED Oct 18, 1938 M. M. Crowe
Local Registrar.

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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, _____
_____, or by _____

Registered Apprentice No. _____, working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.