

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.

Do not use this space.

5653

File No. \_\_\_\_\_  
Registered No. **852**  
St. \_\_\_\_\_ Ward \_\_\_\_\_

Dr. M. M. Crowe  
3626 Grand  
Be 5370

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

1. PLACE OF DEATH  
County **Jackson** Registration District No. **399**  
Township **Kaw** Primary Registration District No. **1002**  
City **Kansas City** (No. **St Joseph Hospital**)  
2. FULL NAME **Mrs Anna McHugh**  
(a) Residence, No. **1009 Admiral Blvd** 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

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Widow**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **John H McHugh**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **March 25, 1864**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
**74 11**

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **At Home**  
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) **Illinois**

13. NAME **Wesley Houlehan**

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

15. MAIDEN NAME **No record**

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

17. INFORMANT **Edward McHugh**  
(ADDRESS) **1009 Admiral Blvd**

18. BURIAL, CREMATION, OR REMOVAL PLACE **St Marys** DATE **Feb 27, 1939**

19. UNDERTAKER **Thomas E Quirk Funeral Home**  
(ADDRESS) **4316 Troost Ave,**

20. FILED **726 1939 M. M. Crowe**  
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **March 25, 1864**

22. I HEREBY CERTIFY, That I attended deceased from **Jan 29** 19**39**, to **Feb 25** 19**39**  
I last saw **et** alive on **Feb 24** 19**39** Death is said to have occurred on the date stated above, at **7.05 A.M.** m.  
The principal cause of death and related causes of importance were as follows:

**Chronic Endocarditis** Date of onset **1-29-39**  
**131**  
Other contributory causes of importance:  
**Chronic Interstitial nephritis** **1-29-39**

Name of operation **W** Date of \_\_\_\_\_  
What test confirmed diagnosis? **W** 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? **no**  
If so, specify \_\_\_\_\_  
(Signed) **Charles Nelson** M. D.  
(Address) **3626 Grand**

