

REC'D JUN 8 1939

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

17731

Do not use this space.

1. PLACE OF DEATH  
(a) County Jackson Registration District No. 399  
(b) Township Kaw Primary Registration District No. 1002  
(c) City Kansas City (d) Street No. St. Joseph Hospital Registered No. 2133  
(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 560 Thomas Reilly O'Meara  
(a) Residence, No. 101 East Winthrop Road 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

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 Mrs. Lina O'Meara

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 1, 1899

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>39</u>	<u>10</u>	<u>20</u>	

OCCUPATION

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

9. Industry or business in which work was done, as saw mill, bank, etc. Arctic Ice Cream

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 City Missouri

FATHER

13. NAME Richard J O'Meara

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

MOTHER

15. MAIDEN NAME Margaret Reilly

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas City Missouri

17. INFORMANT (ADDRESS) Mrs. Thos O'Meara  
101 E Winthrop Rd

18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary Cemetery DATE May 23 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Quirk & Tobin Co  
20 West Linwood

20. FILED May 22 1939 m.m. Brown  
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 21 1939 . 19

22. I HEREBY CERTIFY, That I attended deceased from April 8 39 to May 21 39

I last saw him alive on May 21, 1939. Death is said to have occurred on the date stated above, at 9:15 A. M.

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

Lung Abscess  
RT Lung

Date of onset about April 16

Other contributory causes of importance:

Weather

Name of operation None 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 \_\_\_\_\_, 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) Dr. John O'Sullivan, M. D.  
(Address) 1402 Bryant Bldg.

1226



**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.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH

17731-  
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 344  
 (b) Township J. K. C. Primary Registration District No. 1222 Registered No. 7123  
 (c) City J. K. C. (d) Street No. St. Joseph Hosp 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

(a) Residence, No. 101 E. W. Smithway St. Rfd (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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 21 1939

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

22. I HEREBY CERTIFY, That I attended deceased from

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

I last saw h. alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
29 10 20

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

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

Intestinal abscess  
shock  
anesthesia  
 Date of onset 4-16-

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

Other contributory causes of importance: 1200

13. NAME

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

Name of operator Nervine Date of 4-13-39

15. MAIDEN NAME

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

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

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.

17. INFORMANT (ADDRESS)

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS)

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
 If so, specify \_\_\_\_\_

20. FILED May 22 39 M. M. Crooner (Address) 1402 Belmont Bel.  
 Local Registrar.

(Signed) John D. Skinner M. D.  
 (Address) 1402 Belmont Bel.

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. FEELINGS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

