

WRITE FULLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Joseph Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: 1 hospital or institution  
(Specify whether)

In this community \_\_\_\_\_  
years, months or days

NOV 14 1939

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON

(c) City or town KANSAS CITY  
(If outside city or town limits, write "RURAL")

(d) Street No. 6620 PARK  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME MRS. MARY ANN KELLY 400

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

20. DATE OF DEATH: Month OCT day 1  
year 39 hour 8 minute 10 P.M.

4. Sex FEMALE 5. Color or race WHITE

6. (a) Single, widowed, married, divorced DIVORCED

6. (b) Name of husband or wife JESSE KELLY 6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased OCTOBER 16 - 1875  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 1, 1939, to OCT 1, 1939;  
that I last saw him alive on OCT 1, 1939;  
and that death occurred on the date and hour stated above.

Immediate cause of death CORONARY OCCCLUSION Duration 1 DAY

8. AGE: Years 63 Months 11 Days 25  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to ARTERIAL SCLEROTIC GANGRENE RIGHT FOOT 4 YEARS

9. Birthplace FRANCE  
(City, town, or county) (State or foreign country)

Due to HYPERTENSION 9 1/2 YEARS

10. Usual occupation AT HOME

Other conditions (Include pregnancy within 3 months of death)

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name PETE DURING

13. Birthplace FRANCE  
(City, town, or county) (State or foreign country)

14. Maiden name UNKNOWN

15. Birthplace FRANCE  
(City, town, or county) (State or foreign country)

Major findings: (Specify type of place)  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically

16. (a) Informant's own signature MR. ALBERT C. HOFFT

(b) Address 6620 PARK AVE.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

17. (a) BURIAL (b) Date thereof OCT-3-1939  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

While at work? \_\_\_\_\_  
(Specify type of place) (e) Means of injury

18. (a) Signature of funeral director J. H. Neuenmeier's Sons

(b) Address 1401-BRUSH CREEK BLVD

23. Signature A. C. Gustafson (M. D. or other) M.D.

Address 6944 Maple Rd. L Date signed OCT 1 1939

19. (a) OCT 1 - 1939 (b) M. M. Boone  
(Date received local registrar) (Registrar's signature)

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**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 C. Hervey Dunsenber

Licensed Embalmer No. 4070

P. O. Address K. C. Mo.

**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.**