

WRITE PLAINLY—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.

RECORDED NOV 14 1939

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **4083**

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. Josephs Hospital
(If not in hospital or institution, write street number or location)

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

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

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

(d) Street No. 3144 Summit
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME JOHN T. MURRAY

8. (b) If veteran, name war No

8. (c) Social Security No. No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 23 rd. year 1939 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Catherine Murray

6. (c) Age of husband or wife if alive 72 years 1864

7. Birth date of deceased May 4
(Month) (Day) (Year)

that I last saw him alive on Oct 23, 1939 and that death occurred on the date and hour stated above.

Immediate cause of death _____

8. AGE: Years 75 Months 5 Days 19 If less than one day _____ hr. _____ min.

Duration _____

① Intra capsular Fracture 10 days right hip.

Due to ② Hypertensive - Cardio-vascular heart disease -

Due to ③ Hypostatic pneumonia

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

Other conditions _____ (Include pregnancy within 3 months of death)

10. Usual occupation Inspr. of Automatic Sprink

PHYSICIAN _____

11. Industry or business K. C. Water Dept.

Major findings: _____
Of operations _____
Of autopsy _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER { 12. Name Joseph Murray

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

14. Maiden name Bridget Dunn
(City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature Mrs Catherine Murray

(b) Address 3144 Summit

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

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

17. (a) burial (b) Date thereof 10-26-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(b) Date of occurrence 10/13/39

(c) Place: burial or cremation Calvary Cemetery

(c) Where did injury occur? K.C. Jackson Mo
(City or town) (County) (State)

18. (a) Signature of funeral director Quick & Cohen Co.

(b) Address K.C. Mo.

19. (a) 10/24/39 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Fall on street
(Specify type of place)

While at work _____ Means of injury Fall

23. Signature Garrett Pappin M.D. (M.D. or other)
Address 1318 Bryant Bldg Date signed 10/24

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 Maurice M Quirk

Licensed Embalmer No. 2226

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.