

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

REV. 6-17-39 I 191511

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 38579

DEC 11 1939 399
Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4343

1. PLACE OF DEATH: Jackson 1
(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: In hospital or institution 2 weeks
In this community: Most of life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: 1
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2444 Mersington
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME JOHN SAVAGE 120
3. (b) If veteran, name war No 3. (c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 11 day 11-39
year _____ hour _____ minute 11:15 P. M.

4. Sex Male 5. Color or race Wh 6. (a) Single, widowed, married, divorced. Married
6. (b) Name of husband or wife Mrs. Susan Savage 6. (c) Age of husband or wife if alive 80 years
7. Birth date of deceased January 10 1858
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____, 19____, to 11-11-39, 19____; that I last saw him alive on 11-11-39, 19____; and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
81 10 1 hr. _____ min.

Immediate cause of death
Pneumonia
Due to Acute Haemorrhagic Arteritis and Prostatitis, Bladder 2nd
Due to Prostate Hypertrophy
Other conditions Hypertensive Bronchitis
(Include pregnancy within 6 months of death)
Pulmonary

9. Birthplace Great Crossing Ky
(City, town, or county) (State or foreign country)
10. Usual occupation Retired Contractor 1

Major findings: Of operations Straggle Horn Left
Of autopsy above
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER
12. Name Patrick Savage
13. Birthplace Ireland 3
(City, town, or county) (State or foreign country)
14. Maiden name Bridget Neaton
15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature James G. Shroy
(b) Address 71st and Blue Ridge
17. (a) Burial (b) Date thereof Nov 15, 1939
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. St. Mary's Cemetery
18. (a) Signature of funeral director John W. Wagner
(b) Address Kansas City, Mo.
19. (a) Nov 13 1939 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

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? _____
While at work _____ (Specify type of place) (e) Means of injury _____
23. Signature Russell W. Seer (M. D. or other) _____
Address _____ Date signed _____

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 W. H. Harnsfield

Licensed Embalmer No. 4062

P. O. Address K. E. MD

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.