

Registration District No. 399

Primary Registration District No. 1002

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's Hospital 1
(If not in hospital or institution, write street number & location)
(d) Length of stay: In hospital or institution 8 days.
In this community 45 years. (Specify whether years, months or days)

3. (a) PRINT FULL NAME MAURICO M. QUIRK

3. (b) If veteran, name war none 3. (c) Social Security No. 495-07-5186

4. Sex Male 5. Color of hair Wh 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife McCormick Catherine 6. (c) Age of husband or wife if alive 27 years

7. Birth date of deceased September 24 1879
(Month) (Day) (Year)

8. AGE: Years 60 Months 2 Days 29 If less than one day ✓ hr. ✓ min. ✓

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

10. Usual occupation Funeral director

11. Industry or business Undertaking

12. Name Maurice Quirk

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

14. Maiden name Margaret Quinn

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

16. (a) Informant's own signature Michael Quirk

(b) Address 2017 Harbor

17. (a) burial (b) Date thereof 12/27/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director John P. Quinn

(b) Address Linwood Main

19. (a) Dec. 28, 1939 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Kansas City Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 800 Westover Rd.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 50 yrs years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 23 year 1939 hour 10:45 minute 10 M.

21. I hereby certify that I attended the deceased from December 23 to December 23, 1939; that I last saw him alive on Dec 23, 1939; and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia
Due to Infection strep. p. p.
Due to Dec 19 39

Other conditions Bacterial Infection
(Include pregnancy within 3 months of death) None

Major findings: Of operations None
Of autopsy None

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 Dr. John P. Quinn (M.D. or other) 12/27/39
Address 1409 Bryant St. Mo. Date signed _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically

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.

I X1051

MAR 7 1946

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 Harold P. King

Licensed Embalmer No. 4097

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.