S. No. —11-10-39 v. 5-17-39 I X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 1 1940

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 5255

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 490

**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: 2648 E. 7th St. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution About 50 Yrs. (Specify whether years, months or days) In this community

**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. 2648 E. 7 th. St. (If rural, give location)

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

8. (a) PRINT FULL NAME Mrs. Mary Kane Endres

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Fe.

5. Color or race Wh.

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

6. (b) Name of husband or wife Peter

6. (c) Age of husband or wife if alive 0 years

7. Birth date of deceased Feb. 2. 1875 (Month) (Day) (Year)

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 64 | 11 | 29 | hr. min. |

9. Birthplace Co. Mayo, Ireland (City, town, or county) (State or foreign country) 5

10. Usual occupation General Hospital #1 5

11. Industry or business Laundry--10 Years. 5

MOTHER FATHER

12. Name James Kane

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

14. Maiden name Bridget Fitzpatrick

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

16. (a) Informant Mrs Irvin Johnson

(b) Address 2648 East 7th St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 3. 1940 (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's Cemetery

18. (a) Signature of funeral director Thos. E. Qurik Funeral Home

(b) Address 4316 Troost

19. (a) Feb. 2, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Feb. day 1. year 1940 hour 3:05 minute ____ M.

21. I hereby certify that I attended the deceased from 1-15-, 1940 to 2/1, 1940 that I last saw her alive on 2/1, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia 1-15/40 Duration

Due to

Due to Ruptured Right femoral artery 96

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

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

23. Signature D. R. Russell (M. D. or other)

Address 3231 E. 11 St. Date signed

(Licensed Embalmer's Statement on Reverse Side)

## 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 Thomas L. Funk

Licensed Embalmer No. 3775

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.**