

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **1003**

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:  
K.C. General Hospital No. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 Mo. (Specify whether  
In this community 20 Yrs.  
years, months or days)

8. (a) PRINT FULL NAME Sophia O'Malley 541  
8. (b) If veteran, name war No 8. (c) Social Security No. No

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced. Married  
6. (b) Name of husband or wife James E. O'Malley 6. (c) Age of husband or wife if alive 61 years  
7. Birth date of deceased May 24th. 1888  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
81 9 7 hr. min.

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

10. Usual occupation Housewife

11. Industry or business  
12. Name Soloman Baker  
13. Birthplace Unknown (State or foreign country)  
14. Maiden name Maria Dier  
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature James O'Malley  
(b) Address 2741 Chelsea

17. (a) ~~Burial~~ Removal date thereof 3/5/40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Hillsdale Kans.

18. (a) Signature of funeral director W. M. Meyberg  
(b) Address 2315 Linwood Blvd.

19. (a) 3-4-40 (b) M. M. Carver  
(Date received local registrar) (Registrar's signature)

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. 2741 Chelsea  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month March day 3rd  
year 1940 hour 7 minute 30 P. M.

21. I hereby certify that I attended the deceased from 2-1-40, 19\_\_\_\_, to 3-3-40, 19\_\_\_\_;  
that I last saw h. ER alive on 3-3-40, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Fracture of femur, accidental fall in home

Due to 186a  
Due to i.

Other conditions Terminal bronchopneumonia  
(Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings:  
Of operations None  
Of autopsy \_\_\_\_\_  
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) Acc.  
(b) Date of occurrence 2-1-40 4P-  
(c) Where did injury occur? K.C. Mo.  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

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

23. Signature C. E. De Munn (M. D. or other) Fall  
Supt. K.C. Gen. Hospital, K.C. Mo. Date signed \_\_\_\_\_  
Address \_\_\_\_\_

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

Rev. 5-17-39 N. B. 1 X10511

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.

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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 *H. E. Snow*

Licensed Embalmer No..... 2560

P. O. Address 2315 Linwood Blvd.

**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.