

Registration District No. **399**

Primary Registration District No. **1002**

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

**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:  
613 Main  
(If not in hospital or institution, write street number or location) **2**  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community Unknown  
years, months or days)

3. (a) PRINT FULL NAME John J. Connell 540

3. (b) If veteran name war   
3. (c) Social Security No. 495-10-2230

4. Sex male 5. Color or race wh 6. (a) Single, widowed, married, divorced  9

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive 1 years

7. Birth date of deceased Unknown  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
off 60 hr. min.

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

10. Usual occupation Labor

11. Industry or business P.M.A.

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Parents Owners Office

(b) Address Jackson Co Mo

17. (a) Burial (b) Date thereof 5/2/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Lawn Cem

18. (a) Signature of funeral director A. Schelley

(b) Address 901 East 5th St

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

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limit, write "RURAL")  
(d) Street No. 613 Main  
(If rural, give location)  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 4 day 30  
year 40 hour \_\_\_\_\_ minute P M.

21. I hereby certify that I attended the deceased from Crown, 19\_\_\_\_;

that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic heart disease

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) 95%

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

23. Signature [Signature] (M. D. or other) 5/2/40

Address [Signature] Date signed 5/2/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

**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: Ray E. Linn

Licensed Embalmer No. 2560

P. O. Address 1807 E 29

**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.**