

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.

**OCT 11 1940**

399

1002

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

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: 3249 Penn.  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 month  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME John Shay

3. (b) If veteran, name war. \_\_\_\_\_ 3. (c) Social Security No. none

4. Sex m race w  
 5. Color or \_\_\_\_\_  
 6. (a) Single, widowed, married, divorced widowed  
 6. (b) Name of husband or wife Betty Lee 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased 18 1851  
(Month) (Day) (Year)

8. AGE: Years 88 Months 8 Days 14  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace no data Conn.  
(City, town, or county) (State or foreign country)

10. Usual occupation Groceryman Retired

11. Industry or business \_\_\_\_\_

12. Name Patrick Shay

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

14. Maiden name unk known

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

16. (a) Informant's own signature Mr. C. E. Oaks

(b) Address 3249 Penn. Kansas

17. (a) Removal (b) Date thereof 9-2-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Parsons Kansas

18. (a) Signature of funeral director R. A. Fulton

(b) Address Kans. City Kans

19. (a) Sept 23 1940 (b) M. M. Cronin  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State KANSAS (b) County \_\_\_\_\_  
 (c) City or town GIRARD  
(If outside city or town limits, write "RURAL")  
 (d) Street No. R. F. D.  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 2nd  
 year 1940 hour 13<sup>00</sup> minute A M.

21. I hereby certify that I attended the deceased from Aug 1st  
1940, to Sept 29, 1940  
 that I last saw him alive on Sept 2, 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 2 wks.  
 Due to Cerebral Arteriosclerosis.

Due to Arteriosclerotic Heart Disease

Other conditions Uremia - Chr. Nephritis  
(Include pregnancy within 3 months of death)

Major findings: none 101  
 Of operations none  
 Of autopsy none

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 9-2-40  
 (c) Where did injury occur? at home (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State) \_\_\_\_\_  
 (d) Did injury occur in or about home, or farm, or industrial place, or public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (d) Means of injury \_\_\_\_\_

23. Signature J. A. Roy (M. D. or other) M.D.  
 Address 1002 Angell Bldg Date signed 9/13/40

**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. M. Sauter*

Licensed Embalmer No. *235K*

P. O. Address *1225*

**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.**