

NOV 12 1940

Registration District No. _____ Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**
 (b) City or town **Kansas City Mo.**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
1336 Bellefontaine Ave. **3**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **1 Day.**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **George W. MOONEY.**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **No**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**

6. (b) Name of husband or wife **Nora Mooney** 6. (c) Age of husband or wife if alive **years**

7. Birth date of deceased **July 3rd 1868**
(Month) (Day) (Year)

8. AGE: Years **82** Months **3** Days **18** If less than one day hr. min.

9. Birthplace **Marshall Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Farmer**

11. Industry or business

MOTHER FATHER { 12. Name **Nicolis Mooney**
 18. Birthplace **Ireland**
(City, town, or county) (State or foreign country)
 14. Maiden name **Mary Cooney**
 15. Birthplace **Ireland**
(City, town, or county) (State or foreign country)

16. (a) Informant **Joseph M. Maloney (Nephew)**
 (b) Address **1336 Bellefontaine Ave.**

17. (a) **Removal** (b) Date thereof **10/22/40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Marshall Missouri.**

18. (a) Signature of funeral director **Melody-McGilley**

(b) Address **K. E. Mo.**

19. (a) **10-22-40** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Saline**
 (c) City or town **Rural**
(If outside city or town limit, write "RURAL")
 (d) Street No. **Marshall Missouri**
(If rural, give location)
 (e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **21st**
 year **1940** hour **2** minute **15 P.M.**

21. I hereby certify that I attended the deceased from **Oct 21**, 19**40** to **Oct 21**, 19**40**
 that I last saw h— alive on **Oct 21**, 19**40**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Heart failure** Duration

Due to **Myocard Rupture**

Due to **Old age**

Other conditions (Include pregnancy within 3 months of death) **9/26**

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?
3/6 (Specify type of place) _____
 While at work? _____ (e) Means of injury _____
 23. Signature **R. L. [Signature]** (M. D. or other) _____
 Address **5242 [Address]** Date signed **10/22/40**

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

Dr. St. Clair
101 S. Lawn.

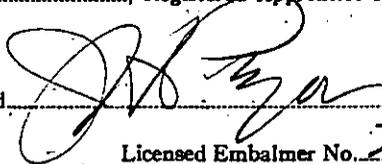
STATEMENT BY LICENSED EMBALMER

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



Licensed Embalmer No. 2999

P. O. Address R.C. m

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.