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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
NOV 12 1940

MISSOURI STATE BOARD OF HEALTH
# STANDARD CERTIFICATE OF DEATH

State File No. 34594

Registration District No. 399 | Primary Registration District No. 1002 | Registrar's No. 4110

**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: 1617 Montgal (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Missouri (b) County Jackson
(c) City or town Kansas City Missouri (If outside city or town limits, write "RURAL")
(d) Street No. 1617 Montgal (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Frank P. Mulvihill
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 Married
6. (b) Name of husband or wife Cecilia Alma Mulvihill
6. (c) Age of husband or wife if alive 50 years
7. Birth date of deceased Oct. 10 1876 (Month) (Day) (Year)

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 64 ~~71~~ | 0 | 15 | hr. min. |

9. Birthplace Kansas (City, town, or county) (State or foreign country)
10. Usual occupation Retired Cabinet Maker
11. Industry or business
MOTHER FATHER
12. Name Patrick Mulvihill
13. Birthplace Ireland (City, town, or county) (State or foreign country)
14. Maiden name Mary Sullivan
15. Birthplace Ireland (City, town, or county) (State or foreign country)
16. (a) Informant Mrs Cecilia Mulvihill
(b) Address 1617 Montgal
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 26 1940 (Month) (Day) (Year)
(c) Place: burial or cremation St Mary
18. (a) Signature of funeral director Mrs. E. L. Foster
(b) Address 911 Brooklyn
19. (a) 10-27-40 (Date received local registrar) (b) R. M. Brown (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month October day ~~26~~ 25 year 1940 hour 7 minute 25 A.M.
21. I hereby certify that I attended the deceased from Oct ~~24~~ 23, 1940, to Oct ~~25~~ 24, 1940; that I last saw him alive on Oct ~~25~~ 24, 1940 and that death occurred on the date and hour stated above.

| Immediate cause of death | Duration |
|---|---|
| Uremia | 2 days |
| Due to Nephritis (Probably Chr) Dur Known | |
| Due to | |
| Other conditions Prostatic Carcinoma (Include pregnancy within 3 months of death) | |

(51)

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

23. Signature J. J. Davis M.D. (M. D. or other)
Address 901 Waldheim Bl Date signed Oct 25

(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 Me

....., Registered Apprentice No.....

working under my personal supervision.

Signed E. H. Wise

Licensed Embalmer No. 2570

P. O. Address K. C. Mo.

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**