

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **4432**

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:
3404 Wayne
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **42 years**
years, months or days)

3. (a) PRINT FULL NAME **JOHN J. REGAN**
3. (b) If veteran, name war **No**
3. (c) Social Security No. **None**

4. Sex **Male**
5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Margaret O'Loughlin**
6. (c) Age of husband or wife if alive **63** years
7. Birth date of deceased **March 24, 1875**
(Month) (Day) (Year)

8. AGE: Years **65** Months **7** Days **25** If less than one day _____ hr. _____ min.

9. Birthplace **Co. Clare, Ireland**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired**

11. Industry or business **Police Department**

MOTHER FATHER
12. Name **James Regan**
13. Birthplace **Ireland**
(City, town, or county) (State or foreign country)
14. Maiden name **Ann McMahon**
15. Birthplace **Ireland**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Mrs. Margaret Regan**
(b) Address **3404 Wayne**
17. (a) **Burial** (b) Date thereof **11/22/40**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **St. Mary's Cemetery**

18. (a) Signature of funeral director **Swick & Fabian Co.**
(b) Address **Hannan City, Mo.**
19. (a) **11-20-40** (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 limits, write "RURAL")
(d) Street No. **3404 Wayne**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? **42 years** years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Nov. 19** day _____
year **1940** hour **1** minutes **20** P. M.
21. I hereby certify that I attended the deceased from **August 13th 1940 to Nov. 19 1940**
that I last saw him alive on **Nov. 17 1940**
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of Stomach**
Due to _____
Due to **46**

Other conditions (Include pregnancy within 3 months of death)
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?
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **H. P. Dougherty** (M. D. or other) **M. D.**
Address **Prof. Belg. H. C. Dr.** Date signed **11/22/40**

Duration **8 Mo**
PHYSICIAN
Underline the cause to which death should be charged statistically

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. SEE CHANGING BLACK INK—MAKE A PERMANENT RECORD

FILED DEC 11 1940

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.....

Harold Perry

Licensed Embalmer No. *4097*

P. O. Address *K.C. Mo.*

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.