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Registration District No. 85

Primary Registration District No. 1001

Registrar's No. 1203

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

NOV DEC 1940

PLACE OF DEATH:
(a) County Buchanan
(b) City or town St. Joseph
(c) Name of hospital or institution: Flannigan Nursing Home 2018 Francis St
(If outside city or town limits, write "RURAL" and name of township)
(d) Length of stay: In hospital or institution 1 year.
(Specify whether years, months or days) 76 years.

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. 2426 Olive Str.
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME John T. Whalen

3. (b) If veteran, name war None 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 Maude Whalen 6. (c) Age of husband or wife if alive 55 years

7. Birth date of deceased June 20 1864
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>	<u>4</u>	<u>25</u>	hr. _____ min.

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

10. Usual occupation Retired Building Contractor

11. Industry or business Feeney Construction Co.

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 Mrs. Maude Whalen

(b) Address 2426 Olive St. St. Joseph, Mo.

17. (a) Burial (b) Date thereof Nov. 16, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director H.O. Sidenfaden & Son

(b) Address 1802 Union Str. St. Joseph, Mo.

19. (a) Nov. 16, 1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month NOV. day 15th
year 1940 hour 7 minute 30 P. M.

21. I hereby certify that I attended the deceased from 2/1 - 1940
to 11/14 1940
that I last saw h im alive on 11/14
and that death occurred on the date and hour stated above.

Immediate cause of death Heart Disease
Myocardial infarction
Chronic Coronary

Due to _____
Due to _____
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?
85 _____
While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature [Signature] (M. D. or other) [Signature]
Address [Address] Date signed 11/16-40

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.....

Albert C. Harrington

Licensed Embalmer No.....

3258

P. O. Address.....

St. Joseph, 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, fact should be so stated above.