

FILED JAN 8 1941  
Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **4620**

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: 1100 Summit **2**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 45 years (years, months or days)

3. (a) PRINT FULL NAME FANNIE KEEGAN

3. (b) If veteran, name war Fannie Keegan **No** 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Thomas Keegan 6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased June 19 1869  
(Month) (Day) (Year)

8. AGE:			If less than one day
Years	Months	Days	
<u>71</u>	<u>5</u>	<u>14</u>	hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business 9

12. Name John Daniels

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 Mr. Thomas Keegan

(b) Address 1100 Summit, K.C. Mo.

17. (a) Burial (b) Date thereof 12-5-1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director J. F. O'Connell Co.

(b) Address 3256 Broadway, K.C. Mo.

19. (a) 12-4-40 (b) M. M. Crowe  
(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. 1100 Summit  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 3  
year 1940 hour 8 minute 40 P. M.

21. I hereby certify that I attended the deceased from Sept. 15 - 19  
1940 to Dec. 2, 1940

that I last saw her alive on Dec. 2, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
<u>Cerebral hemorrhage</u>	<u>10 days</u>
Due to <u>Hypertension</u>	<u>15 years</u>
Due to _____	_____

Other conditions Deceased has had several cerebral emboli. Has been analyzed by

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) 210  
(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 1

23. Signature Irish Conrad (M. D. or other)  
Address 1308 Waldheim Bg. Date signed Dec. 4-40

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

**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 Park G. Rowe  
Licensed Embalmer No. 2347  
P. O. Address K. L. 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.**