

FILED JAN 8 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **41350**
Registrar's No. **4743**

Registration District No. **399**

Primary Registration District No. **1002**

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:
Little Sisters of Poor
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 years, 9 months**
In this community **59 yrs**
years, months or days

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. **5331 Highland**
(If rural, give location)
(e) If foreign born, how long in U. S. A. **59 years** years.

3. (a) PRINT FULL NAME **MARY DEEGAN**

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

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

6. (b) Name of husband or wife **Thomas Deegan**
6. (c) Age of husband or wife if alive **unknown** years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years **68** Months Days If less than one day hr. min.

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

10. Usual occupation **None**

11. Industry or business

12. Name **John Walsh**

13. Birthplace **Ireland**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Harrington**

15. Birthplace **Ireland**
(City, town, or county) (State or foreign country)

16. (a) Informant **Little Sisters of Poor**

(b) Address **5331 Highland**

17. (a) **Burial** (b) Date thereof **12/14/40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Josephs, Shawnee**

18. (a) Signature of funeral director **Quirk & Falusi Co.**

(b) Address **H. O. Tru**

19. (a) **12/13/40** (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **11**
year **1940** hour **9:45** minute **P.** M.

21. I hereby certify that I attended the deceased from **Nov 19**
1940, to **Dec 11**, 19**40**;
that I last saw her alive on **Dec 11**, 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Thrombosis**
3 weeks

Due to **Hypertension**

Due to **Arteriosclerosis**

Other conditions **94%**
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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 **T**

23. Signature **John T. Shumier** (M. D. or other) **MD**

Address **1402 Bryant Bldg** Date signed **12-12-40**

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

MOTHER FATHER

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.....

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.