

FILED JAN 8 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **41353**

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **4746**

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 the Poor
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **11 years**
(Specify whether
In this community **11 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? _____ years.

8. (a) PRINT FULL NAME **JOHN HENIFF**

9. (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 **Widower**
6. (b) Name of husband or wife **Harriet Thedge** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **about 1858**
(Month) (Day) (Year)

8. AGE: Years **82** Months **3** Days _____ If less than one day hr. _____ min.

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

10. Usual occupation **None**

11. Industry or business _____

MOTHER FATHER { 12. Name **John Heniff**
18. Birthplace **No record**
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name **Julia Mullen**
15. Birthplace **No record**
(City, town, or county) (State or foreign country)

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

(b) Address **5331 Highland**

17. (a) **Burial** (b) Date thereof **Dec 13 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Marys' Cemetery**

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

(b) Address **1410 No**

19. (a) **1/13/40** (b) **M. M. Browne**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **10th** day **Dec**
year **1940** hour **9:15** minute **P** M.

21. I hereby certify that I attended the deceased from **July 29**, 19**40** to **Dec 10**, 19**40**
that I last saw him alive on **Dec 10**, 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death
Pulmonary Tuberculosis
Due to **Myocardiasis**
Due to **Generalized arterio-sclerosis**
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy **No**

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 **John T. Skinner** (M. D. or other) **MD**
Address **11402 Brynau** Date signed **12-12-40**

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

ACMO

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. 4297

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.