

MAR 14 1941

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: K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days last am.
(Specify whether
In this community 5 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

Missouri Jackson
(a) State (b) County
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
4611 Forest
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 11th
year 1941 hour 5 minute 55 A. M.

21. I hereby certify that I attended the deceased from
2-9-41, 19, to 2-11-41, 19;
that I last saw him alive on 2-11-41, 19;
and that death occurred on the date and hour stated above.

Immediate cause of death
CORONARY OCCLUSION WITH MYOCARDIAL
INFARCTION

Duration

Due to 7/10
Due to 1/11
Other conditions
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations _____
Of autopsy See above
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? _____

(Specify type of place) _____
While at work? _____ to means of injury 0
23. Signature James R. Stone (M. D. or other) _____
Address Med. Dir. K.C. Gen. Hospital, Kansas City, Mo.

3. (a) PRINT FULL NAME PETER KEATING

3. (b) If veteran, name war no 3. (c) Social Security No. NO

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced wid 2

6. (b) Name of husband or wife Mary Keating 6. (c) Age of husband or wife if alive years

7. Birth date of deceased June 8 1875
(Month) (Day) (Year)

8. AGE: Years 65 Months 8 Days 3 If less than one day hr. min.

9. Birthplace Penn 1
(City, town, or county) (State or foreign country)

10. Usual occupation Real Estate

11. Industry or business _____

12. Name Thomas Keating

13. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

14. Maiden name Bridget McMan

15. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Jas. O'Leary

(b) Address Wilrose Lane

17. (a) Removal (b) Date thereof Feb-11 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Norton Maus

18. (a) Signature of funeral director Mr C R Foster

(b) Address 918 Brooklyn
19. (a) 2/11/41 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

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

5-17-39

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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 me
....., Registered Apprentice No.
working under my personal supervision.

Signed Leffrise

Licensed Embalmer No. 2570

P. O. Address K O M

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.