

No. 2
-11-10-39
5-17-39
-1 X21482

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **5887**
Registrar's No. **659**

Registration District No. **399**

Primary Registration District No. **1002**

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

I. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Joseph Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **30 Yrs.** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City Mo.**
(If outside city or town limits, write "RURAL")
(d) Street No. **3322 Highland Ave.** (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME **Mrs. Dorothy A. DEGAN.**

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

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

6. (b) Name of husband or wife **Richard J. Degan** 6. (c) Age of husband or wife if alive, years **29th**

7. Birth date of deceased **August 29th 1872**
(Month) (Day) (Year)

8. AGE: Years **68** Months **5** Days **14** If less than one day _____ hr. _____ min.

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

10. Usual occupation **At Home.**

11. Industry or business _____

MOTHER FATHER { 12. Name **Patrick Kinney** 13. Birthplace **Ireland**
(City, town, or county) (State or foreign country)

14. Maiden name **Dont know** 15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Richard A. Degan**

(b) Address **3322 Highland, K.C. Mo.**

17. (a) **Burial** (b) Date thereof **2/15/41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Melody-McGilley**
(b) Address **K. C. Mo.**

19. (a) **2/14/41** (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **February** day **13th**
year **1941** hour **9:30 P.** minute _____ M.

21. I hereby certify that I attended the deceased from **Aug - 1939**
_____ 19____ to **Feb 13** 19**41**;
that I last saw her _____ alive on **Feb 13** 19**41**
and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia**
Hy postatis Duration **4 day**

Due to **Cerebral haemorrhage**

Due to **arteriosclerosis**

Other conditions **62nd**
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy **62nd**

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 **D**

23. Signature **M. C. Scharrer** (M. D. or other) _____
Address **5450 Troost** Date signed **2-14-41**

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 267
....., Registered Apprentice No.

working under my personal supervision.

Signed JH Ryon
.....
Licensed Embalmer No. 2999
.....
P. O. Address KC
.....

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.