

Registration District No. 399

Primary Registration District No. 1002

18
26
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 8 days (Specify whether 0)

In this community 40 years
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 048

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 11 East 32nd St.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME THOMAS R. Manahan

3. (b) If veteran, name war _____

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 11th
year 1941 hour 6 minute 05 P. M.

4. Sex Male 5. Color or race white

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Sarah Manahan

6. (c) Age of husband or wife if alive 81 years

7. Birth date of deceased March 15 1859
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 7-3-41 to 7-11-41
that I last saw him alive on 7-11-41
and that death occurred on the date and hour stated above.

Immediate cause of death bilateral Bronchopneumonia
ephrosclerosis

8. AGE:	Years	Months	Days	If less than one day
	<u>82</u>	<u>3</u>	<u>26</u>	hr. min.

Due to Post operative prostatectomy
for benign prostatic hypertrophy

Due to _____

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

Other conditions (include pregnancy within 3 months of death) _____

10. Usual occupation Retired - Piano Salesman

Major findings: Of operations _____

11. Industry or business Jenkins Music Co.

Of autopsy See above

MOTHER FATHER { 12. Name Edward Manahan 4

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

14. Maiden name Anna Higgeson
(City, town, or county) (State or foreign country)

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

16. (a) Informant Mrs. Sarah Manahan
(b) Address 11 East 32

17. (a) Burial (b) Date thereof 7/14/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's Cemetery

18. (a) Signature of funeral director Quirk and Tobin Co.
(b) Address H. C. Co.

19. (a) 7-13-41 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

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? _____

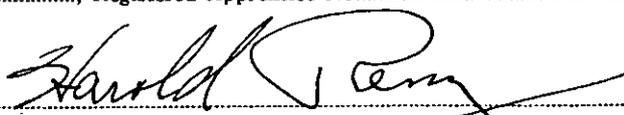
(Specify type of place) _____
While at work (c) Means of injury _____

23. Signature Drury R. Thore (M. D. or other) 1
Address Med. Dir. K.C. Gen. Hospital Date signed _____

121

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..... 

Licensed Embalmer No. 4097

P. O. Address K.C. 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 24091
Registrar's No. 2630

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town K.C.
(c) Name of hospital or institution: Gen Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Thos. R. Manahan

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

4. Sex m 5. Color or race W 6. (a) Single, widowed, married, divorced m

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

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

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

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 7/27/41 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

20. DATE OF DEATH: Month July day 11 - 41
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death Relat. Bronchitis Duration _____
meningitis
nephrosclerosis

Due to P. D. prostate disease for
benign hypertrophy of prostate.

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: 137a
Of operations _____
Of autopsy _____

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 _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

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

MOTHER FATHER

PHYSICIAN
Underline the cause to which death should be charged statistically.

