No. 2
—1-4-41
5-17-39
I X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
SEP 12 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27265

Registration District No. 397 Primary Registration District No. 1002 Registrar's No. 2923

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

8
3
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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 U
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days (Specify whether
In this community 30 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 8
(If outside city or town limits, write "RURAL")

(d) Street No. 5232 College 8
(If rural, give location)

(e) Citizen of foreign country? Nos (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME AGNES CONNORS

3. (b) If veteran, name war No

3. (c) Social Security No. no

4. Sex Femal

5. Color or race White

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

6. (b) Name of husband or wife John Connors

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

7. Birth date of deceased Nov 4 1879
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	61	8	27	hr. min.

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

10. Usual occupation At Home

11. Industry or business

FATHER
12. Name Mc Donald
13. Birthplace Ireland
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Haley
15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant Mr Eddie Connors
(b) Address 5233 College

17. (a) Burial (b) Date thereof Aug 4 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Marys Cem.

18. (a) Signature of funeral director Mrs C.L.Forster
(b) Address 918 Brooklyn

19. (a) 8/3/41 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31st
year 1941 hour 4:00 P.M. minute M.

21. I hereby certify that I attended the deceased from 7-27-41, 19, to 7-31-41, 19;
that I last saw her alive on 7-31-41, 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Fracture of left hip, caused by accidental fall in home	
Due to	
Due to	
Other conditions Sebaceous cysts of anterior chest wall and mediastinum (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy See above

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 1 2 3
(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? (e) Means of injury

23. Signature Nancy R. Shorn (M. D. or other) 0
Address Med.Dir.K.C.Gen.Hospital,K.C.Mo Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 J. Clair Shepard

Licensed Embalmer No. 4179

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.

S. No. 2B
M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27265

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 2923

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:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

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

3. (a) PRINT FULL NAME Agnes Connors
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced Wid
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 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
MOTHER FATHER
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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 31 year 1941 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hemorrhage of left hip caused by accidental fall in home	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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) accident
(b) Date of occurrence 7-27-41
(c) Where did injury occur? Home-K.C. (City or town) Jackson (County) Mo (State)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? Home (Specify type of place)
While at work? No (c) Means of injury Fall
23. Signature Dewey P. Bloom (M. D. or other)
Address Medw. KC Gen Hosp Date signed 10-4-41

SUPPLEMENTARY

186a
18

Died. Dis. K.C. Gen Hosp. K.C. Mo