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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

30887

FILLED OCT 13 1944

Registration District No.

Primary Registration District No.

1002

Registrar's No.

2015

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution: 5120 Lydia 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 40 years (Specify whether years, months or days)
In this community 40 years

3. (a) PRINT FULL NAME Michael Nolan

3. (b) If veteran, name war no 3. (c) Social Security No. 196-07-4228

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

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

7. Birth date of deceased. Nov 7, 1882
(Month) (Day) (Year)

8. AGE: Years 57 Months 10 Days 23 If less than one day hr. min.

9. Birthplace Council Bluffs, Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Night Watchman

11. Industry or business Morris-Hoffman

12. Name Michael Nolan

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

14. Maiden name Mary O'Keefe

15. Birthplace Jefferson Barracks, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Catherine Nolan

(b) Address Valentine Hotel

17. (a) Burial (b) Date thereof 9-30-41
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director J. E. & T. J. Co.

(b) Address St. Louis, Mo.

19. (a) 9/30/41 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

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. 5120 Lydia 0
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 29
year 1941 hour 5 minutes 15 a. m.

21. I hereby certify that I attended the deceased from Sept. 16
1941 to Sept. 29, 1941;
that I last saw him alive on Sept. 25, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death myocarditis Duration _____

Due to _____

Due to _____

Other conditions In testicular destruction
(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) _____

(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 S. P. Ford (M. D. or other) D

Address Parkville Mo Date signed 9-29-41

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

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. *4097*
P. O. Address..... *K.C., Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply 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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No. 599

Primary Registration District No. 1002

Registrar's No. 3645

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:
5120 Lydia
 (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 Michael Nolan

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

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

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 9/30/41 In. In. Crowe

19. (a) (Date received local registrar) (b) (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) If foreign born, how long in U. S. A.? years.

DECLARATION OF CERTIFICATION

20. DATE OF DEATH. Month Sept. day 29th 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.

Immediate cause of death Myocarditis chronic

Due to 930

Due to Cause undetermined

Other conditions Intestinal obstruction
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations 930

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?

(Specify type of place)
 While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

1941

S-30887