No. 2
1-4-41
17-39
X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 11 1942

Registration District No. 399

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 1228

Primary Registration District No. 1002

Registrar's No. 157

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: 3707 Jefferson
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 60 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City 40
(If outside city or town limits, write "RURAL")

(d) Street No. 3707 Jefferson 3
(If rural, give location)

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

If yes, name country 0

3. (a) PRINT FULL NAME JOHANNA HALEY

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widow 2

6. (b) Name of husband or wife Thomas J Haley

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

7. Birth date of deceased Dec (Month) 29 (Day) 1862 (Year)

8. AGE: Years 79 Months 0 Days 15 If less than one day ..... hr. ..... min.

9. Birthplace St Louis (City, town, or county) Mo (State or foreign country)

10. Usual occupation At Home

11. Industry or business

FATHER
12. Name Thomas Jennings
13. Birthplace (City, town, or county) N.C. (State or foreign country)

MOTHER
14. Maiden name Mary
15. Birthplace (City, town, or county) N.S. (State or foreign country)

16. (a) Informant Mrs Agnes De Gouveia
(b) Address 3707 Jefferson

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-14-42 (Month) (Day) (Year)
(c) Place: burial or cremation Mt St Marys

18. (a) Signature of funeral director Jos O'Donnell Co
(b) Address 3756 Broadway KC Mo

19. (a) 1-13-42 (Date received local registrar) (b) M. M. Crow (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 12
year 1942 hour ..... minute ..... A.M.

21. I hereby certify that I attended the deceased from Dec 24, 1941, to Jan 12, 1942
that I last saw her alive on Dec 24, 1942
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Cardiac failure	
Due to Hypertension	3
Due to Senility	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of autopsy .....

162

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

23. Signature C. C. Wilson C (M. D. ~~Teacher~~)
Address Plaza Medical Bldg KCMo Date signed 1/13/42

(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 Park G. Rowe

Licensed Embalmer No. 2347

P. O. Address K. C. Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
-2-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. Primary Registration District No. Registrar's No. 157

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County

(b) City or town (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) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Johanna Haley

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex FE

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 79 | 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

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

MOTHER
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) 1/13/42 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 12 year 1942 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 Cardiac failure

Due to Arteriosclerosis Hypertension

Due to Senility 97

Other conditions N. N. O. 11
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature [signature] (M. D. ~~[illegible]~~) MD

Address Plaza Middlesex Kl Date signed 7

S-1228