

Registration District No. 11 10029

Primary Registration District No. 1002

Registrar's No. 3245

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 6 days
(Specify whether years, months or days)

In this community 60 years
(Specify whether years, months or days)

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. 824 Linwood
(If rural, give location)

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

If yes, name country X

3. (a) PRINT FULL NAME Mrs. Sarah Elizabeth Connell

3. (b) If veteran, name war no.

3. (c) Social Security No. no.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 29th
year 1942 hour 11 minute 25 P. M.

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

6. (b) Name of husband or wife William Connell 6. (c) Age of husband or wife if alive dec years

7. Birth date of deceased July 19 1855
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 8-23-42, 19... to 8-29-42, 19...;

that I last saw her 8-29-42 alive on 8-29-42 and that death occurred on the date and hour stated above.

8. AGE: Years 87 Months 1 Days 10
If less than one day hr. min.

Immediate cause of death LOBAR PNEUMONIA

Due to 108

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

10. Usual occupation at home

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy None

11. Industry or business X

12. Name Flynn

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

14. Maiden name Mulligan

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

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant Miss Dee Connell

(b) Address Park Central Hotel, Kansas City, Mo

17. (a) Burial (b) Date thereof 9-1-42
(Burial, cremation, or removal) (Month) (Day) (Year)

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

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?.....

18. (a) Signature of funeral director Stine & McClure

(b) Address 3235 Gillham Plaza, K. C. Mo.

19. (a) 8-31-42 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

While at work (Specify type of place) means of injury

23. Signature Dr. R. J. Brown (M. D. or other)

Address Med. Dir. K.C. Gen. Hospital K.C. Mo.

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

MOTHER FATHER

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.....

P. O. Address.....

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.