

S. No. 2
 M-5-42
 v. 5-17-39
 I X32873

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

39874

State File No.

FILED JAN 11 1943

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4859

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

1. PLACE OF DEATH:
 (a) County Jackson County
 (b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Little Sisters of the Poor
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 1/2 yrs
(Specify whether years, months or days)
 In this community 2 1/2 years

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Jackson
 (c) City or town K. C., Mo
(If outside city or town limits, write "RURAL")
 (d) Street No. 5331 Highland
(If rural, give location)
 (e) Citizen of foreign country? 0 (Yes or No)
 If yes, name country 0

3. (a) PRINT FULL NAME Mary Moran
 (b) If veteran, name war no
 (c) Social Security No. none

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Dec day 27
 year 1942 hour 11 minute P M.

4. Sex female 5. Color or race White
 6. (a) Single, widowed, married, divorced, single
 (b) Name of husband or wife _____
 (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Oct 19 1856
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Dec 1
1942, to Dec 27, 1942
 that I last saw her... alive on Dec 26, 1942
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
86 2 108 hr. min.
 9. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

Immediate cause of death Bronchial pneumonia 4 days
 Due to Broken leg ship - Right 6 days
 Due to Hypertension + arteriosclerosis years

10. Usual occupation no record
 11. Industry or business _____
 12. Name Michael Moran
 13. Birthplace Ireland 4
(City, town, or county) (State or foreign country)
 14. Maiden name Mary Sella
 15. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

Other conditions none
(Include pregnancy within 3 months of death)
 Major findings: Of operations none
 Of autopsy none
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

MOTHER FATHER

16. (a) Informant J. J. Freese
 (b) Address 5931 Highland ave
 17. (a) Burial (b) Date thereof 12-29-42
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation St Mary's Church
 18. (a) Signature of funeral director J. J. Freese
 (b) Address 4316 2nd St
 19. (a) Dec 28 1942 (b) Dr. M. Crow
(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) Acc
 (b) Date of occurrence 1-23
 (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 John Sherman (M. D. or other) M.D.
 Address 402 Bryant St Date signed 12-29-42

X-EMO

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..... *John E. Turk*

Licensed Embalmer No..... *3775*

P. O. Address..... *P. O. Md*

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registrar's No. 4859

Registration District No. Primary Registration District No.

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

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town J. C. Mo
(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)
In this community _____ (Specify whether)
years, months or days

3. (a) PRINT FULL NAME

Mary Moran

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 Months Days If less than one day _____ min.

86

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) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 12/28/42 (b) M. M. Brome (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) If foreign born, how long in U. S. A.? _____ years

DEATH CERTIFICATION

20. DATE OF DEATH Month Dec. day 27 year 1942 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 _____ Duration _____

Bronchial Pneumonia
Due to Broken Hip Right

Due to Hypertension and atherosclerosis

Other conditions (Include pregnancy within 3 months of death)

Major findings: 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 Dec 19 42

(c) Where did injury occur? J. C. Jack Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home

While at work? _____ (Specify type of place)

(e) Means of injury fall

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

186a
18

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-39874