

FILED JAN 30 1943
149

Registration District No.

Primary Registration District No. 1002

Registrar's No. 215

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
3231 Montgall!
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 72 years (Specify whether years, months or days)

In this community 72 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Mr John J Connor

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Elizabeth Connor

6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased January 5 1871
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>72</u>	<u>0</u>	<u>9</u> hr. min.

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

10. Usual occupation City Water Department

11. Industry or business Inspector

MOTHER FATHER

12. Name John Connors

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

14. Maiden name Margaret Madden

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

16. (a) Informant Mrs Elizabeth Connor

(b) Address 2231 Montgall

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-18-43
(Month) (Day) (Year)

(c) Place: burial or cremation St Marys Cemetery

18. (a) Signature of funeral director Melody Mc Kelley

(b) Address Kansas City Mo.

19. (a) 1-15-43 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 3231 Montgall
(If rural, give location)

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

If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 14th
year 1943 hour 5:15 minute P.M.

21. I hereby certify that I attended the deceased from Jan 12 - 1943
....., 19....., to Jan 14....., 19.....
that I last saw him alive on Jan 12....., 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death lobar pneumonia left lower
old chronic pulmonary tuberculosis

Due to old chronic pulmonary tuberculosis

Due to 13 B

Other conditions (Include pregnancy within 3 months of death)

Duration

2 da

PHYSICIAN

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

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?

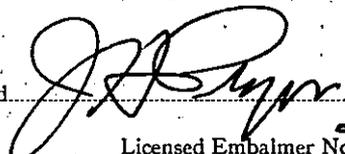
While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature J B Wallace (M. D. or other) Address 783 bathrop bldg Date signed 1-15-43

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 .....
Licensed Embalmer No. 2999.....
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.