

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **969**

FILED MAR 5 1943
Registration District No. **149**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County **Jackson**

(b) City or town **Kaw K.C.**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
401 East 36th. St. /
(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) **10 years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Jackson**

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

(d) Street No. **401 East 36th. St.**
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)
If yes, name country **A**

3. (a) PRINT FULL NAME **Miss Mary A. Cogan**

3. (b) If veteran, name war. **No**

3. (c) Social Security No. **None**

4. Sex **Female**

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 **Aug. 19, 1868**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
74	6	5	hr. min.

9. Birthplace **Leavenworth, Kas.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired School Teacher**

11. Industry or business.....

12. Name **Michael Cogan**

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

14. Maiden name **Margaret Cunningham**

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

16. (a) Informant **Miss Tessie Cogan**

(b) Address **Solomon, Kas.**

17. (a) **Removal** (Burial, cremation, or removal)

(b) Date thereof **Feb. 25, 1943**
(Month) (Day) (Year)

(c) Place: burial or cremation **Chapman, Kas.**

18. (a) Signature of funeral director **Thos. E. Quirk Funeral Home**

(b) Address **4316 Troost Ave.**

19. (a) **2-25-43** (Date received local registrar)

(b) **M. M. Brown** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **24th.**
year **1943** hour **7.15 A.M.** minute..... M.

21. I hereby certify that I attended the deceased from **2** **10** 19**40**, to **2** **24** 19**43**
that I last saw h. **u** alive on **2** **23** 19**43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic myocarditis**
Duration.....

Due to.....

Due to.....

Other conditions.....
(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?.....

23. Signature **J. P. Brinkley** (M. D. or Other)
Address **Kansas City, Mo.** Date signed **26.43**

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 _____
working under my personal supervision.

Registered Apprentice No. _____

Signed _____

Licensed Embalmer No. 3775

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.