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

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 5 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 5323

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 854

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: St. Mary's Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 Days (Specify whether
In this community 60 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 48

(a) State Missouri (b) County Jackson 3

(c) City or town Kansas City 6
(If outside city or town limits, write "RURAL")

(d) Street No. 1512 Poplar
(If rural, give location)

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

If yes, name country 0

3. (a) PRINT FULL NAME Frank McCosgrove

3. (b) If veteran, name war no

3. (c) Social Security No. None

4. Sex Male

5. Color or race White 0

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife

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

7. Birth date of deceased Not known (Month) (Day) 1860 (Year)

8. AGE: Years 83 | Months | Days | If less than one day hr. min.

9. Birthplace (City, town, or county) Ireland 4 (State or foreign country)

10. Usual occupation Laborer

11. Industry or business retired

FATHER
12. Name Frank McCosgrove
13. Birthplace (City, town, or county) Ireland 4 (State or foreign country)

MOTHER
14. Maiden name Alice McCarn
15. Birthplace (City, town, or county) Ireland 4 (State or foreign country)

16. (a) Informant James C. Witherow
(b) Address 2015 East 35th. Street

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 2-19-43 (Month) (Day) (Year)
(c) Place: burial or cremation Edina Missouri

18. (a) Signature of funeral director J. F. Powell
(b) Address 3256 Broadway

19. (a) 2-18-43 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

361

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 17th. year 1943 hour 8 minute 45 P.M.

21. I hereby certify that I attended the deceased from Comm 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 Fracture of the skull

Due to Fall Amb Stairs at home

Due to 186 ay 14

Other conditions Generalized arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy see above

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) Accident 123

(b) Date of occurrence 2/14/43

(c) Where did injury occur? 1512 Poplar KCW (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Comm (Specify type of place)

While at work? W (e) Means of injury

23. Signature [signature] (M. D. or other) 2/18/43

Address CCW Date signed

(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 Paul 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 with the above constitutes grounds for revocation of license.)

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