S. No. 2
M—5-42
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

5388

State File No.

Registration District No. 149 — Primary Registration District No. 1002 — Registrar's No. 1091

ED MAR 15 1943

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

**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 2 Weeks (Specify whether

In this community 30 Years years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 0 (If outside city or town limits, write "RURAL") 0

(d) Street No. RR#4 Independence, Mo. (If rural, give location)

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

If yes, name country 1

**3. (a) PRINT FULL NAME** MATTHEW BERNARD O'CONNELL

3. (b) If veteran, name war no

3. (c) Social Security No. None

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced 3 Divorced

6. (b) Name of husband or wife Tina O'Connell

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

7. Birth date of deceased August 30, 1870 (Month) (Day) (Year)

8. AGE: Years 72 Months 6 Days ~~2~~ 1 If less than one day hr. min.

9. Birthplace (City, town, or county) Indiana 1 (State or foreign country)

10. Usual occupation Switchman retired.

11. Industry or business Missouri Pacific

FATHER
12. Name Maurice J. O'Connell
13. Birthplace (City, town, or county) Ireland 4 (State or foreign country)

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

16. (a) Informant Mrs B. Blakely

(b) Address Kansas City, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 3-3-43 (Month) (Day) (Year)

(c) Place: burial or cremation Indiana Crawfordsville

18. (a) Signature of funeral director Quirk and Tolin Co.

(b) Address 20 West Linwood

19. (a) 3-3-43 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 3 day 1 year 43 hour 4:00 P minute M.

21. I hereby certify that I attended the deceased from Corona, 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion Chronic myocardial infarction

Due to Centre pulmonary edema

Due to 9 4a

Other conditions (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)

(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? (Specify type of place)

While at work? (e) Means of injury

23. Signature [illegible] 3 (M. D. or other)

Address [illegible] Date signed 4/1/43

(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 Charles M Quirk

Licensed Embalmer No. 3774

P. O. Address Kansas City 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.**