S. No. 2
M—5-42
5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 6 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

13283

State File No.

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2017

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. Joseph Hospital 0 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 Days (Specify whether years, months or days) In this community 27 DYears

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48 3

(c) City or town Kansas City (If outside city or town limits, write "RURAL") 8

(d) Street No. St. Joseph Hospital Chaplin (If rural, give location)

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

If yes, name country 0

3. (a) PRINT FULL NAME Cornelius D. McCARTHY

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 May 5th, 1891 (Month) (Day) (Year)

8. AGE: Years 51 Months 11 Days 2 If less than one day hr. min.

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

10. Usual occupation Catholic Priest.

11. Industry or business Clergy

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

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

16. (a) Informant Hospital Records

(b) Address K. C. Mo.

17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 4/29/43. (Month) (Day) (Year)

(c) Place: burial or cremation Colusa, California

18. (a) Signature of funeral director Mellody-McGilley

(b) Address K. C. Mo.

19. (a) 4/29/43 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 27 year 1943 hour 1:10 minute P.M. M.

21. I hereby certify that I attended the deceased from 4-1-43, 19, to 4-27, 1943; that I last saw him alive on 4-27-43, 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Acute Cardiac deletion	5 min
Due to Bronchial plug	10 minute
Due to 126	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations Cholelithiasis c̄ cholecystitis

Of autopsy normal

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 John T. Shannon (M. D. or other) MD

Address 1402 Bryant Bldg KCMC Date signed 4-28-43

(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.....

Licensed Embalmer No.....

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.