

ED JUN 7 1943

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2376

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: Little Sisters of the Poor 5  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 years  
(Specify whether years, months or days)  
In this community 5 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48  
(c) City or town Kansas City 3  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5331 Highland 8  
(If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MRS. ANNA CORCORAN

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Female 1 5. Color or race White 6. (a) Single, widowed, married, divorced Widow 2

6. (b) Name of husband or wife Michael 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased February 17, 1867  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
76 3 4 hr. \_\_\_\_\_ min.

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

10. Usual occupation At home

11. Industry or business \_\_\_\_\_

12. Name Ambrose Michaels

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

14. Maiden name Anna Hart

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

16. (a) Informant Leo Corcoran  
(b) Address 2218 Benton

17. (a) Burial (b) Date thereof 5-24-1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Walter Poliak Co.

(b) Address 20 West Linwood, K.C., Mo.

19. (a) 5-25-43 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 21  
year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from May 19, 1943 to May 21, 1943  
that I last saw her alive on May 21, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to Coronary Thrombosis 3 da

Due to Generalized Arterio-sclerosis yrs

Other conditions None  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 M. M. Crowe (M. D. or other) M. M. Crowe  
Address 16 Bryant Bldg. Date signed 5-25-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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**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 *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.**