

FILED JUN 7 1943
Registration District No.

Primary Registration District No. 1002

Registrar's No. 2126

1. PLACE OF DEATH: Jackson

(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:
K.C. General Hospital D
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution..... 6 days
(Specify whether)

In this community..... 17 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

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

(c) City or town..... Kansas City 3

(d) Street No..... 523 Helping Hand Institute
(If rural, give location) 8

(e) Citizen of foreign country?..... No (Yes or No) 0

If yes, name country.....

3. (a) PRINT FULL NAME..... Thomas P. McCague

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

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

4. Sex..... Male 0

5. Color or race..... W

6. (a) Single, widowed, married, divorced..... Widowed 2

6. (b) Name of husband or wife..... Louise Mc Cague

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

7. Birth date of deceased..... Nov. 8th, 1891
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	51	5	28 hr. min.

9. Birthplace..... Missouri 0
(City, town, or county) (State or foreign country)

10. Usual occupation..... Laborer

11. Industry or business..... Helping Hand

12. Name..... Thomas Mc Cague Sr.

13. Birthplace..... Missouri 0
(City, town, or county) (State or foreign country)

14. Maiden name..... Mary Allen

15. Birthplace..... Tenn. 1
(City, town, or county) (State or foreign country)

16. (a) Informant..... Mr. K. P. Goff

(b) Address..... 307 So. Elmwood St.

17. (a) Burial
(Burial, cremation, or removal) (b) Date thereof..... 5/7/43
(Month) (Day) (Year)

(c) Place: burial or cremation..... Olathe Kansas

18. (a) Signature of funeral director..... Rose & Henderson

(b) Address..... K. C. Missouri

19. (a) 5-7-43 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... May day..... 6th
year..... 1943 hour..... 12 minute..... 55 P. M.

21. I hereby certify that I attended the deceased from..... 5-1-43, 19..... to..... 5-6-43, 19.....
that I last saw him..... alive on..... 5-6-43, 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Military tuberculosis with pneumonia

Due to..... 22a

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy.....

..... See above

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) (a) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Hed. Dir. K. C. Gen. Hospital Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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 *John B. Parpa*
Licensed Embalmer No. *2953-V*
P. O. Address *N.C. Ind*

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.