

FD AUG 11 1943

Registration District No. **149**

Primary Registration District No. **1002**

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 Poor  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 3 days  
(Specify whether years, months or days)  
 In this community 65 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
 (c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 504 W. 17th Street  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME MRS. KATIE DIXON

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

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

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

7. Birth date of deceased September 26, 1856  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
86 10 1 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation At home

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

MOTHER FATHER { 12. Name Michael O'Brien

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

14. Maiden name Bridget Farrell

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

16. (a) Informant John Dixon

(b) Address 926 East 3rd Street

17. (a) Burial (b) Date thereof 7/29/1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. John's Cemetery

18. (a) Signature of funeral director Quirk & John Co.

(b) Address 20 W. Linwood Blvd.

19. (a) 7-28-43 (b) J. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 27th  
 year 1943 hour 1: minute 30 A.M.

21. I hereby certify that I attended the deceased from July 16th  
1943, to July 25, 1943,  
 that I last saw her alive on July 25, 1943, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Uremia Duration 3 da.

Due to Hypertensive heart disease yrs.

Due to Arterio Sclerosis yrs.

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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

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

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Dr. John T. ... (M. D. or other) MD  
 Address 1401 28th Street Date signed 7-27-43

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

---

---

**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. Zwick

Licensed Embalmer No. 3774

P. O. Address Kansas City

**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.**

Registration District No. 149 Primary Registration District No. 1002

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Perran city  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME Kate Wilson  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Sept 26 1891  
(Month) (Day) (Year)

8. AGE: Years 46 Months 14 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month July Day 27 year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; \_\_\_\_\_, 19\_\_\_\_;

that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immediate cause of death Uremia acute from acute nephritis

Due to Hypertensive heart disease - arteriosclerotic

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (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) (c) Means of injury \_\_\_\_\_

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

Address \_\_\_\_\_ Date signed \_\_\_\_\_

**SUPPLEMENTARY**

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

MOTHER FATHER

PHYSICIAN  
Underline the cause to which death should be charged statistically.

S-23807.