

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED SEP 21 1943 149

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 3852

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:
5331 Highland /
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 years
(Specify whether years, months or days)
 In this community 3 Years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson 48
 (c) City or town Kansas City 5
(If outside city or town limits, write "RURAL") 8
 (d) Street No. 5331 Highland
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____ 1

3. (a) PRINT FULL NAME MICHAEL ROONEY

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

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

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

7. Birth date of deceased June 9 1874
(Month) (Day) (Year)

8. AGE: Years 69 Months 2 Days 24 If less than one day 36 hr. _____ min.

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

10. Usual occupation None

11. Industry or business _____

12. Name Michael Rooney

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

14. Maiden name Elizabeth Cooney

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

16. (a) Informant Little Sisters of Poor

(b) Address 5331 Highland Ave

17. (a) Burial (b) Date thereof 9/7/1943
(Burial, cremation, or removal) (Month) (Day) (Year)

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

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

(b) Address 20 West Linwood

19. (a) 9-7-43 (b) P. C. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 5, year 1943 hour 8: minute 05 P.M.

21. I hereby certify that I attended the deceased from Aug 15th 1943 to Sept 4 1943 that I last saw him alive on Sept 4 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis 2 days
Arterio Sclerosis 94a
 Due to _____ years
 Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)
 Major findings:
 Of operations _____
 Of autopsy no

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? _____

While at work? _____ (Specify type of place)
 (e) Means of injury _____
 23. Signature John Thurner (M. D. or other) MD
 Address 1140 2 Bryant Bldg Date signed _____

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.