

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

Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Mary's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 Weeks (Specify whether
In this community 25 Years (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Rev. Thomas F. KANE

8. (b) If veteran, name war None 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 November 22 1892
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
50 10 27 hr. _____ min.

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

10. Usual occupation Clergy

11. Industry or business Priest At Lamar, Mo

MOTHER FATHER { 12. Name Thomas F. Kane
18. Birthplace Unknown Ireland
(City, town, or county) (State or foreign country)
14. Maiden name Catherine Kennedy
15. Birthplace Unknown Connecticut
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Angeline McKnerney (Sister)
(b) Address New Briton, Conn

17. (a) Burial (b) Date thereof 10-21-43
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St Mary's Cemetery

18. (a) Signature of funeral director Melody-McGilley
(b) Address Kansas City Missouri.

19. (a) 10-21-43 (b) Dr P. E. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Barton
(c) City or town Lamar, Missouri
(If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? No / years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 19
year 43 hour 12.45 minute _____ M.

21. I hereby certify that I attended the deceased from 1-1-43
_____ 19____, to _____ 19____
that I last saw him alive on 10-15- 1943
and that death occurred on the date and hour stated above.

Immediate cause of death myelogenous leukemia

Due to _____
Due to 74a

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) (e) Means of injury _____

23. Signature J. P. Bonke (M. D. or other)
Address City Date signed 10-11-43

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

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

Russell G. France

Licensed Embalmer No. 4255

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, above space should be left blank.