

FILED JAN 5 1944
149
Registration District No. _____

Primary Registration District No. 1002

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

1. PLACE OF DEATH: Jackson

(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: General Hospital
(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 55 Years

3. (a) PRINT FULL NAME Bridget A. KELLY

3. (b) If veteran, name war Nonw

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Patrick J. Kelly

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

7. Birth date of deceased February 3rd 1864
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	79	10	22	_____ hr. _____ min.

9. Birthplace County Mayo Ireland 4
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business At Home

MOTHER FATHER

12. Name J J. Ruane

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

14. Maiden name Margaret Welch

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

16. (a) Informant Mr John Kelly

(b) Address 5410 Tracy Street

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof 12-28th-43
(Month) (Day) (Year)

(c) Place: burial or cremation St Marys Cemetery

18. (a) Signature of funeral director Melody-McGilley

(b) Address Kansas City Missouri

19. (a) 12-27-43 (Date received local registrar)

(b) N. E. Brown (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 18

(c) City or town Kansas City Missouri 5
(If outside city or town limits, write "RURAL")

(d) Street No. 2718 Madison Street 8
(If rural, give location)

(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 25
year 43 hour 2:30 minute P M.

21. I hereby certify that I attended the deceased from Crown, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: Fracture of the pelvis
Fall from stool

Due to _____

Due to _____

Other conditions Anterior Anemia
(Include pregnancy within 3 months of death) 1860

Major findings: _____

Of operations: _____

Of autopsy: Fracture of pelvis

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) Accident 19.3

(b) Date of occurrence 1/11/43

(c) Where did injury occur? 7601 Winona Rd Kew
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home

While at work? No (Specify type of place) (e) Means of injury _____

23. Signature N. E. Brown 3 12/25/43
Address _____ 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 *Russell N 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, fact should be so stated above.