DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 1559

FILED FEB 3 1944

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 287

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 609 East 9th St. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community 12 year

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

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

(d) Street No. 609 East 9th St. (If rural, give location)

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

3. (a) PRINT FULL NAME Michal J. McGlynn

3. (b) If veteran, name war unk

3. (c) Social Security No. unk

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife unk

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

7. Birth date of deceased 5 (Month) 18 (Day) 1877 (Year)

8. AGE: 72 Years 66 Months 7 Days 27 If less than one day hr. min.

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

10. Usual occupation Retired R.R. Man

11. Industry or business

FATHER 12. Name Patrick McGlynn

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

MOTHER 14. Maiden name Mary Mullen

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

16. (a) Informant Pat McGlynn

(b) Address R.R. #2 K.C.K.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-18-44 (Month) (Day) (Year)

(c) Place: burial or cremation St Joseph Missouri Kansas

18. (a) Signature of funeral director G.H. Barnes

(b) Address 22 Kansas

19. (a) Jan 18 1944 (Date received by local registrar) (b) J. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 15 year 1944 hour 4 minute 30 p.m.

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

Immediate cause of death: Arteriosclerotic Heart Disease

Due to: 93h

Due to:

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy Inspection

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? (Specify type of place)

While at work? (e) Means of injury?

23. Signature Jo E. Turner M.D. (M. D. or other)

Address 22 N. Cay Date signed 1/16/44

(Licensed Embalmer's Statement on Reverse Side)

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

NOV 20 1953

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 Carl G Rowe

Licensed Embalmer No. 2347

P. O. Address KC Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.