

FILED MAR 6 1944

State File No.

910

Registration District No.

749

Primary Registration District No.

1002

Registrar's No.

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:
601 E. Armour
(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 20 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. 601 E. Armour
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

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200

3. (a) PRINT FULL NAME Thomas Charles Kehoe

3. (b) If veteran, name war World War, 1
 3. (c) Social Security No. 702-07-1267

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

6. (b) Name of husband or wife Faye
 6. (c) Age of husband or wife if alive 35 years

7. Birth date of deceased Sept. 27, 1897
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
46 4 27 hr. _____ min.

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

10. Usual occupation Secretary to Superintendent

11. Industry or business K. C. Frisco Ry.

MOTHER FATHER
 12. Name John D. Kehoe
 13. Birthplace Oswego, New York
(City, town, or county) (State or foreign country)
 14. Maiden name Margaret O'Melia
 15. Birthplace Oswego, N. Y.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Faye Kehoe

(b) Address 601 E. Armour

17. (a) Burial (b) Date thereof 2/21/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director C. H. Blackman & Son, Inc

(b) Address Kansas City, Mo

19. (a) 2-25-44 (b) P. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 24
 year 1944 hour 8 minute 15 M.

21. I hereby certify that I attended the deceased from Sept 15
1941 to Feb 24, 1944
 that I last saw him alive on Feb 24, 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death _____

Acute myocardial failure 20M stroke

Due to myocardial degeneration 3 yrs

Due to hypertension years

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? _____

(Specify type of place) _____
 • While at work? _____ (e) Means of injury _____

23. Signature John Schuman (M. D. or other) MD

Address 1102 Grand Ave Date signed 2-26-44

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

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K. EMO

*Dr. Skunk
Bryant / Bldg.*

MAR 2 2 1944

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.