

FILED FEB 18 1944

Registration District No. **447**

Primary Registration District No. **100 ✓**

Registrar's No. **543**

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:
105 E 31st Terrace 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community **10 years**
years, months or days)

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. **105 E. 31st Terrace**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **0**

3. (a) PRINT FULL NAME **EDWARD O'SHAUGHNESSY**

MEDICAL CERTIFICATION

3. (b) If veteran, name war **No** 3. (c) Social Security No. **No**

20. DATE OF DEATH Month **FEB.** day **A**
year **1944** hour **9** minute **25 P.** M.

4. Sex **Male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **WIDOWED**
6. (b) Name of husband or wife **MARY O'SHAUGHNESSY** 6. (c) Age of husband or wife if alive **4** years
7. Birth date of deceased **AUG 1861**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Feb 1, 1944** to **Feb 1, 1944**
that I last saw him alive on **Feb 1, 1944**
and that death occurred on the date and hour stated above.

8. AGE: Years **82** Months **5** Days **27** If less than one day hr. min.

Immediate cause of death **Influenza**
Due to **senility**
Due to **poor nutrition**
Other conditions **arteriosclerosis, cancer of prostate**
(Include pregnancy within 3 months of death)

9. Birthplace **BOSTON MASS 1**
(City, town, or county) (State or foreign country)

10. Usual occupation **RETIRED COAL-MINER**

Major findings: **arteriosclerosis, cancer of prostate**
operations.
Of autopsy **USA**
PHYSICIAN
Underline the cause to which death should be charged statistically.

11. Industry or business

12. Name **THOMAS O'Shaughnessy**

13. Birthplace **COUNTY GALWAY IRELAND**
(City, town, or county) (State or foreign country)

14. Maiden name **MARY CAHILL**

15. Birthplace **COUNTY GALWAY IRELAND**
(City, town, or county) (State or foreign country)

16. (a) Informant **Miss James Cross**

(b) Address **105 E 31st Terr**

17. (a) **BURIAL** (b) Date thereof **2-2-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **MENDON, MD**

18. (a) Signature of funeral director **Geo. M. Collins**

(b) Address **1103 W. Winner Independence Mo**

19. (a) **2-2-44** (b) **T. E. Brown (RB)**
(Date received local registrar) (Registrar's signature)

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)

(c) Means of injury **0**

23. Signature **W. J. ...** (M. D. or other)

Address **303 ...** Date signed **2-2-44**

DR HUGH GESTRING

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 *George M. Collier*

Licensed Embalmer No. *3839*

P. O. Address *Indep. 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.