

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: K. C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days
(Specify whether
In this community 68 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. 4514 E. 15 St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME John W. Mulholland

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

4. Sex Ma 5. Color or race Wh 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Lillie Mulholland 6. (c) Age of husband or wife if alive XX years
7. Birth date of deceased August 23 1859
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>84</u>	<u>6</u>	<u>14</u>	hr. _____ min. _____

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

10. Usual occupation Retired Contractor

11. Industry or business _____

12. Name John Mulholland

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

14. Maiden name White Ragan

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

16. (a) Informant Agnes Shannon

(b) Address 5532 Charlotte

17. (a) Burial (b) Date thereof 3-10-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood Cemetery

18. (a) Signature of funeral director J. W. Wagner

(b) Address Kansas City, Mo.

19. (a) 3-9-44 (b) N. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 7
year 1944 hour 8 minute 55 P.M.

21. I hereby certify that I attended the deceased from March 4 1944 to March 7 1944
that I last saw him alive on March 7 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic heart disease and Bronchopneumonia

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy None

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)
By means of injury _____

23. Signature A. E. Warner (M. D. or other) Med. Dir.

Address 22 N. 1st Date signed 3-8-44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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..... *Cecil R. Matthes*

Licensed Embalmer No. *3807*

P. O. Address..... *Kansas City, Missouri*

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.