

FILED MAY 1 1944
Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 1627

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

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution Kansas City Tuberculosis Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 mo + 29 days
In this community 58 years
years, months or days (Specify whether)

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. 4125 Kenilworth
(If rural, give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME WILLIAM F. COMISKEY, Sr.
(b) If veteran, name war NO
(c) Social Security No. 496-09-8310

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 10 year 1944 hour 8 minute 45 P. M.

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced, married
(b) Name of husband or wife Miss Comiskey 6. (c) Age of husband or wife if alive 55 years
7. Birth date of deceased 4-24-1885
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 2-12 1944, to 4-10 1944, that I last saw him alive on 4-10 1944 and that death occurred on the date and hour stated above.

8. AGE: Years 58 Months 11 Days 21 If less than one day hr. _____ min. _____

Immediate cause of death Pulmonary Tuberculosis with Tuberculous Laryngitis
Due to _____
Due to _____

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

Other conditions (Include pregnancy within 3 months of death)
Due to _____
Due to _____
Other conditions _____

10. Usual occupation Brewery worker

Major findings:
Of operations _____
Of autopsy Same 13/5
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER
11. Industry or business Brewery
12. Name Thomas Comiskey
13. Birthplace New York New York
(City, town, or county) (State or foreign country)
14. Maiden name Maie Kemmer
15. Birthplace Tinkana Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Patent
(b) Address X-C. T. B. Hoop

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? _____

17. (a) Burial (b) Date thereof April 13, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Thos. H. Quirk Funeral Home
(b) Address 4316 Frost Ave.

23. Signature Marshall J. Hood (M. D. or other) _____
Address _____ Date signed _____

19. (a) 4-13-44 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

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.....

Thomas E. Jirik

Licensed Embalmer No: *3775-*

P. O. Address: *R.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.