

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUL 8 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20328

Registration District No. 149

Primary Registration District No. 1002

State File No. _____

Registrar's No. 2695

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: General Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 days
(Specify whether
In this community 40 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson ⁴⁸
(c) City or town Kansas City, Mo. ³
(If outside city or town limits, write "RURAL")
(d) Street No. 104 W. Linwood
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country U

3. (a) PRINT FULL NAME William F. Riordan
3. (b) If veteran, name war No 3. (c) Social Security No. no #

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day 26
year 1944 hour 10 minute 40 P.M.

4. Sex MALE 5. Color or race W 6. (a) Single, widowed, married, divorced Married
(b) Name of husband or wife Jane E. Riordan 6. (c) Age of husband or wife if alive 68 years
7. Birth date of deceased NOV 2 1869
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____;
that I last saw h. Regina Croner, _____, 19____;
and that death occurred on the date and hour stated above.

8. AGE: Years 74 Months 7 Days 24 If less than one day _____ hr. _____ min.

Immediate cause of death Bronchopneumonia
Due to Saceration of vessels
(Self inflicted)
Other conditions: 164 el

9. Birthplace New York, N.Y. (City, town, or county) (State or foreign country)
10. Usual occupation Salesman
11. Industry or business Consolidated Lobster Co.
12. Name John Riordan
13. Birthplace Ireland (City, town, or county) (State or foreign country)
14. Maiden name No Record
15. Birthplace _____ (City, town, or county) (State or foreign country)

Major findings: Of operations _____
Of autopsy See Above
PHYSICIAN
Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Jane E. Riordan
(b) Address 104 W. Linwood
17. (a) Burial (b) Date thereof 6 28 44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Columbus
18. (a) Signature of funeral director Frank J. Labin
(b) Address 20 W. Linwood
19. (a) 6-28-44 (b) D. E. Brown
(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) Suicide
(b) Date of occurrence June 21, 1944
(c) Where did injury occur Kansas City, Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work No (Specify type of place) (2) Means of injury Saceration
23. Signature A. E. Userer (M. D. or other) M.D.
Address 13. Mc Coy Date signed 6/27/44

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.