

S. No. 2
M-5-43
v. 5-17-39
I X36671

FILED SEP 22 1944

Registration District No. **149**

Primary Registration District No. **1002**

Registrar's No. **3653**

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:
St. Joseph Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **40 minutes**
(Specify whether)
 In this community **63 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. **4100 Montgall**
(If rural, give location)
 (e) Citizen of foreign country? **0** (Yes or No)
 If yes, name country **0**

3. (a) PRINT FULL NAME **MRS. MARY A HARBORD**
 3. (b) If veteran, name war **No**
 3. (c) Social Security No. **None**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **7th** day **Sept**
 year **1944** hour **5:00** minute **P** M.

4. Sex **Female** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Charles L Harobrd**
 6. (c) Age of husband or wife if alive **77** years
 7. Birth date of deceased **Aug 10**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from
Pathologist to **19**
 that I last saw him **alive on** **19**
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	78	0	27	hr. min.

Immediate cause of death **Generalized arteriosclerosis**
Cardiac hypertrophy
and dilatation
Arteriosclerosis
 Due to **(Arteriosclerotic Cardiovascular and renal disease)**
 Other conditions **(Include pregnancy within 3 months of death)**

9. Birthplace **England**
(City, town, or county) (State or foreign country)
 10. Usual occupation **Housewife**

PHYSICIAN
 Major findings: **131a**
 Of operations **As above**
 Of autopsy **As above**
 Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business
 12. Name **John J O'Neill**
 13. Birthplace **Ireland**
(City, town, or county) (State or foreign country)
 14. Maiden name **Bridget Noon**
 15. Birthplace **Ireland**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Urban R Meyers**
 (b) Address **4100 Montgall**
 17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **9/11/44**
(Month) (Day) (Year)

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?

(c) Place: burial or cremation **Calvary Cemetery**
 18. (a) Signature of funeral director **Dwight K. Rubin Co.**
 (b) Address **20 West Linwood**
 19. (a) **9-9-44** (Date received local registrar) (b) **T. E. Brown** (Registrar's signature)

While at work? (Specify type of place) (e) Means of injury **0**
 23. Signature **brain removed** (M. D. or other)
 Address **Pathologist** Date signed

St. Joseph Hospital, K.C., Mo.

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 Charles M. Zwick

Licensed Embalmer No. 3774

P. O. Address Kansas City 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.