

FILED OCT 9 1944

Registration District No. 179 Primary Registration District No. 1002 Registrar's No. 3928

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 4das 10
(Specify whether years, months or days)

In this community 28years
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City Missouri
(If outside city or town limits, write "RURAL")

(d) Street No. 6023 East 15th St Terr
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country no

3. (a) PRINT FULL NAME William Oscar Ireland

3. (b) If veteran, name war no

3. (c) Social Security No. 487 03 1329

4. Sex Male 5. Color or race wh

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Bonnie Ann Ireland

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased June 10th 1884
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>60</u>	<u>3</u>	<u>18</u>	hr. min.

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

10. Usual occupation Electrician

11. Industry or business Ireland

12. Name Ireland

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

14. Maiden name Bell

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

16. (a) Informant Mrs Bonnie Ann Ireland

(b) Address 6023 East 15th St Terr

17. (a) Burial (b) Date thereof Sept 30th 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cemetery

18. (a) Signature of funeral director Cylar Funeral Home

(b) Address 1800 Linwood

19. (a) 9-30-44 (b) N. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 28th year 1944 hour 11 minute A.

21. I hereby certify that I attended the deceased from 18/4 to Sept 28 1944

that I last saw him alive on Sept 28 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Rheumatic heart disease

Due to Ventricular failure

Other conditions: None
(Include pregnancy within 3 months of death)

Major findings: 92C

Of operations: _____

Of autopsy: _____

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)

(a) Means of injury CC no

23. Signature W. D. Brown (M. D. or other) MD

Address CC no Date signed 9/29/44

Duration 20yrs 3 months

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Dr. Ketcham
Waldheim Bg
VI6708

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. *2644*

P.O. Address. *1800 Linwood*

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.