

7. S. No. 2
DOM-5-43
Rev. 5-17-39
Form I X36671

30254

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED SEP 22 1944

Registration District No.

Primary Registration District No. 1002

Registrar's No.

3599

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:
2610 Madison 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days) 60 years

In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 2
(If outside city or town limits, write "RURAL")

(d) Street No. 2610 Madison 8
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____ 17

3. (a) PRINT FULL NAME MRS. KATE McNAMARA

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Widow 2

6. (b) Name of husband or wife Frank McNamara

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

7. Birth date of deceased Aug 15 1864
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>80</u>	<u>0</u>	<u>19</u>	hr. _____ min. _____

9. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Thomas Collins

13. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

14. Maiden name No record

15. Birthplace No record 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Josephine Dawson

(b) Address 2610 Madison Ave

17. (a) Burial (b) Date thereof Sept 6 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Marys Cemetery

18. (a) Signature of funeral director Wm R. Robin Co

(b) Address 20 West Linwood

19. (a) 9-5-44 (b) D. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4th day Sept
year 1944 hour 3:15 minute A M.

21. I hereby certify that I attended the deceased from June 30th 1944 to Sept 4, 1944
that I last saw her alive on Aug 31, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Hypostatic (brown) Pneumonia
Arteriosclerosis
+ Dementia
Senility

Due to _____ 4 day 15 hrs

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death) 108

Major findings:
Of operations _____
Of autopsy _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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 _____ (Specify type of place)
(a) Means of injury _____

23. Signature Edwin Green (or of other) _____
Address 1010 Professional Bldg (City or town) _____

KCO us 10/44

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.