

S. No. 2  
M-5-42  
v. 5-17-39  
I X32873

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36789

State File No.

4645

FILED DEC 4 1944 / 149  
Registration District No.

Primary Registration District No. 1002

Registrar's No.

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: 5642 Harrison  
(If not in hospital or institution, write street number or location) 1  
(d) Length of stay: In hospital or institution. 61 yrs. (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson 48  
(c) City or town Kansas City 3  
(If outside city or town limits, write "RURAL") 8  
(d) Street No. 5642 Harrison  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No) n  
If yes, name country

3. (a) PRINT FULL NAME Mrs. Mary Theresa Killiger

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Female 5. Color or race Wh 6. (a) Single, widowed, married, divorced, Widow  
6. (b) Name of husband or wife unknown 6. (c) Age of husband or wife if alive, years  
7. Birth date of deceased Feb. 6 1882  
(Month) (Day) (Year)

8. AGE: Years 62 Months 9 Days 11 If less than one day hr. min.

9. Birthplace Troy N. Y. (City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business

MOTHER FATHER { 12. Name Michael Kennedy  
13. Birthplace Troy N. Y. (City, town, or county) (State or foreign country)  
14. Maiden name No Rec. rd  
15. Birthplace No Record (City, town, or county) (State or foreign country)

16. (a) Informant Miss Mary Jane Killiger  
(b) Address 5642 Harrison

17. (a) Burial (b) Date thereof 11-20-44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Thos. E. Quirk  
(b) Address 4316 Troost Ave.

19. (a) 11-18-44 (b) T. E. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 17 year 44 hour 6 minute 30 AM

21. I hereby certify that I attended the deceased from Feb 17<sup>th</sup> 1937 to Nov. 17<sup>th</sup> 1944  
that I last saw her alive on Oct. 28<sup>th</sup> 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Heart Disease  
Hypertension Duration 7 yrs

Due to Diabetes Mellitus 7 yrs  
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 61  
Of autopsy 61  
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 work? (Specify type of place) (c) Means of injury 6

23. Signature James Smith (M. D. or other) 6  
Address 718 Prof. Bldg. Date signed 11/17/44

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

K.C. No.

**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. Quirk  
Licensed Embalmer No. 9775  
P. O. Address K 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.**