

FILED DEC 9 1944

State File No. 4831
Registrar's No. 4831

Registration District No. _____

Primary Registration District No. 1002

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's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 mos.
In this community 2 mos.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Buchanan
(c) City or town St. Joseph 11
(If outside city or town limits, write "RURAL")
(d) Street No. 2415 S. 12th 7
(If rural, give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Margaret Waldron

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 Married
6. (b) Name of husband or wife Patrick 6. (c) Age of husband or wife if alive 68 years
7. Birth date of deceased July 5 1883
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>61</u>	<u>4</u>	<u>23</u>	hr. min.

9. Birthplace St. Louis Mo (City, town, or county) (State or foreign country)

10. Usual occupation at Home

11. Industry or business _____

MOTHER FATHER
12. Name Jas. Cooney 14
13. Birthplace Ireland (City, town, or county) (State or foreign country)
14. Maiden name Cooney unknown
15. Birthplace Ky (City, town, or county) (State or foreign country)

16. (a) Informant Patrick A. Waldron
(b) Address St. Joseph Mo

17. (a) removal (b) Date thereof 11-30-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Olivet Cem.

18. (a) Signature of funeral director A. W. Sidenfaden
(b) Address 1802 Union St. St. Joseph, Mo

19. (a) 11-30-44 (b) T. E. Brumby
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 28
year 1944 hour 4 minute 50 p.M.

21. I hereby certify that I attended the deceased from Sept. 27, 1944 to Nov. 28, 1944
that I last saw her alive on Nov. 28, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cholelithiasis fistula

Due to Biliary damage and jaundice with fatty change in the liver.

Other conditions Toxemia
(Include pregnancy within 3 months of death)

Major findings: As above
Of operations _____
Of autopsy As above

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?
(Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature Ernie Sherwood (M. D. certifier)
Address Pathologist Date signed 11-28-44

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

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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.