

FILED JAN 4 1945

Registration District No. **149**

Primary Registration District No. **1002**

Registrar's No. **5164**

838

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

1. PLACE OF DEATH:

(a) County **Jackson**

(b) City or town **Kansas City**

(c) Name of hospital or institution: **Reseal**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **10 days**
In this community **48 years**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **JOHN O'BRIEN**

3. (b) If veteran, name war **none**

3. (c) Social Security No. **510-05-4799**

4. Sex **M** Color or race **wh**

5. Color or race **wh**

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

6. (b) Name of husband or wife **Mary**

6. (c) Age of husband or wife if alive **66** years

7. Birth date of deceased **Dec 27 1875**
(Month) (Day) (Year)

8. AGE: Years **68** Months **11** Days **18**
If less than one day hr. min.

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

10. Usual occupation **Labour**

MOTHER FATHER

11. Industry or business

12. Name **Robert O'Brien**

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

14. Maiden name **Margaret Kelly**

15. Birthplace **N. Ireland** **4**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Mary O'Brien**

(b) Address **217 N. 23rd St. Kansas**

17. (a) **Removal** (b) Date thereof **12-18-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **795 Kansas Highland Pl**

18. (a) Signature of funeral director **P. A. Sullivan**

(b) Address **1000 Kansas**

19. (a) **12-19-44** (b) **N. E. Brown**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Kansas** (b) County **Wauzatchie** **9901**

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

(d) Street No. **217 N. 23rd**
(If rural, give location)

(e) Citizen of foreign country? **(Yes or No)**
If yes, name country **2**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **12** day **15**
year **1944** hour minute M.

21. I hereby certify that I attended the deceased from **12 5**
5, 19**44**, to **12-15**, 19**44**
that I last saw him alive on **12-15**, 19**44**
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of stomach**
Chronic angina
Due to **arteriosclerosis & nephritis**
Due to **Phalangeal disease - Urinary suppression**
Other conditions **465**
(Include pregnancy within 3 months of death)

Duration

Major findings: **gastrectomy**

Of operations

Of autopsy

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) (e) Means of injury **0**

23. Signature **Paul Hunt** (M. D. or other)

Address **1612 Park 130th** Date signed **12-18-44**

9761 56 1006

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... *PA Helton*

Licensed Embalmer No. *3503*

P. O. Address *Ke Kasser*

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.