

FILED JAN 17 1945

Registration District No. 1002

Primary Registration District No. 1002

Registrar's No. 17

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. ~~unknown~~ 12-22-44
(Specify whether years, months or days) as above 1-2-45

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 54

(c) City or town Higginsville, 2
(If outside city or town limits, write "RURAL") 1

(d) Street No. _____ (If rural, give location)

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

If yes, name country X

3. (a) PRINT FULL NAME John F. Kelly

3. (b) If veteran, name war no. _____ 3. (c) Social Security No. no. _____

4. Sex Male 5. Color of race White 6. (a) Single, widowed, married, divorced, Single

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

7. Birth date of deceased June 24 1858
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

85	6	9	hr. min.
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9. Birthplace Washington, D. C. 1
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business farm

12. Name Jerry Kelly

13. Birthplace Ireland 11
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Sullivan, Ireland 11
(City, town, or county) (State or foreign country)

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

16. (a) Informant Hader Funeral Home, 1

(b) Address Higginsville, Missouri,

17. (a) removal (b) Date thereof 1-3-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Higginsville, Mo.

18. (a) Signature of funeral director Stine & McClure,

(b) Address 3235 Gillham Plaza, Kansas City, Mo.

19. (a) 1-3-45 (b) D. E. Brown
(Date received by registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 2
year 1945 hour 6:00 minute P. M.

21. I hereby certify that I attended the deceased from 12-22-44 to 1-2-45, 1945

that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Fracture of right ilium

Due to Fall at home

Due to Uremia

Other conditions Hypostatic Pneumonia
(Include pregnancy within 3 months of death)

Major findings: 1860-5
Of operations 18

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident at home 054

(b) Date of occurrence not known 12-22-44

(c) Where did injury occur? Higginsville Mo.
(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 fall

23. Signature Wm. Williams (M. D. or other)

Address 836 Lytle Bldg Date signed Jan 3

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

8032

For W. J. Williams
Cryer & Sons / P. RR.
MAR 15 1945

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 Robert H. Pread

Licensed Embalmer No. 2746-

P. O. Address H. E. P. RR.

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.