

FILED FEB 17 1945

Registration District No. 799

Primary Registration District No. 1002

Registrar's No. 601

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: St. Luke's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 31 min
(Specify whether years, months or days)

In this community 31 min
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Katharine Lucille Kilbane

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Female

5. Color or race W

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

6. (b) Name of husband or wife -

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

7. Birth date of deceased 1-10-45
(Month) (Day) (Year)

8. AGE: Years - Months - Days -
If less than one day hr. 31 mins

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

10. Usual occupation Infant

11. Industry or business

MOTHER FATHER { 12. Name Frank Thomas Kilbane

MOTHER FATHER { 13. Birthplace Council Bluffs Iowa
(City, town, or county) (State or foreign country)

MOTHER FATHER { 14. Maiden name Mary Grace LaBella

MOTHER FATHER { 15. Birthplace Kansas City Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mother - Mary Kilbane

(b) Address 3803 East 18th St. K.C. Mo.

17. (a) Cremation (b) Date thereof 1-10-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Lukes

18. (a) Signature of funeral director " Hoop

(b) Address K.C. Mo.

19. (a) 2-6-45 (b) P. E. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 3803 East 18th St.
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JANUARY day 10th
year 1945 hour 8:45 minute P M.

21. I hereby certify that I attended the deceased from 1-10-45
1-10-45, 1945, to 1-10-45, 1945;
that I last saw her alive on 1-10-45, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death Oedema - asphyxia

Due to Brech. = Temperature 103° F. fetal membranes always to part to Cervix - membranes rupture 3 days

Other conditions 161 a
(Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy Oedema = no injuries

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 0

23. Signature Dwight G. Hamelt (M. D. or other)

Address 1107 Bryant Date signed _____

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.