

S. No. 2
DM-8-43
v. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 17724
Registrar's No. 5787

FILED JUN 5 2 1945

Registration District No. _____ Primary Registration District No. 4390

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

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1. PLACE OF DEATH:

(a) County Osage

(b) City or town Meta
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Osage

(c) City or town Meta, Mo.
(If outside city or town limits, write "RURAL")

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

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

If yes, name country _____

3. (a) PRINT FULL NAME Kain Bridget ~~Kane~~ Fennessey

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

4. Sex Female 5. Color or race W

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

6. (b) Name of husband or wife Thomas Fennessey 6. (c) Age of husband or wife if alive deceased years

7. Birth date of deceased Aug. 29, 1867
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 7 year 1945 hour 4 minute 30 p. M.

21. I hereby certify that I attended the deceased from March 20 1945 to April 7 1945

that I last saw her alive on April 7 1945 and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>78</u>	<u>7</u>	<u>10</u>	hr. _____ min. _____

Immediate cause of death Chronic myocarditis
Chronic nephritis

Due to _____

Dec to _____

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

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

10. Usual occupation Housewife

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings:
Of operations _____

Of autopsy _____

MOTHER FATHER {

11. Industry or business _____

12. Name Joseph Kane

13. Birthplace U. S. A.
(City, town, or county) (State or foreign country)

14. Maiden name Bridget ~~Kane~~ Cushion

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

16. (a) Informant Mary M. Eads

(b) Address Eldorado, Kans.

17. (a) Burial (b) Date thereof Apr. 9, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director H. S. Strop

(b) Address Meta, Mo.

19. (a) 4/8/45 (b) Rosa Rowan
(Date received local registrar) (Registrar's signature)

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 Henry B. Rosenberg (M. D. or other) _____

Address Meta, Mo. Date signed 4/8/45

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(Licensed Embalmer's Statement on Reverse Side)

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 H. H. Strop
Licensed Embalmer No. 2924
P. O. Address Meta 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.