

FILED JUL 30 1945

State File No.

Registration District No.

Primary Registration District No.

Registrar's No.

3020

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: K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 19 days
In this community unknown (Specify whether years, months or days)

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. Helping Hand Institute
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME

James O'Day

3. (b) If veteran, name war: no

3. (c) Social Security No. none

4. Sex male 5. Color or race white
6. (a) Single, widowed, married, divorced unknown
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: 10 13 72
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 22nd
year 1945 hour 10 minute 55 P. M.
21. I hereby certify that I attended the deceased from 6-3-1945, 19... to 6-22-1945, 19...
that I last saw him alive on 6-22-1945, 19...
and that death occurred on the date and hour stated above.

Immediate cause of death:

Bronchopneumonia

Due to:
Due to:

Other conditions (include pregnancy within 3 months of death) 107

Major findings: Of operations:

Of autopsy:

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 Clark W. Sealy (M. D. or other)
Address Med. Sir. K.C. Gen. Hospital 6-23-45
Date signed:

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

MOTHER FATHER

11. Industry or business:
12. Name John O'Day
13. Birthplace Ireland (City, town, or county) (State or foreign country)
14. Maiden name Margaret Delaney
15. Birthplace Ohio (City, town, or county) (State or foreign country)
16. (a) Informant R.R.L.
(b) Address General Hospital
17. (a) Burial (b) Date thereof 7-20-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Bed 2
18. (a) Signature of funeral director John A. ...
(b) Address City ...
19. (a) 7-19-45 (b) Edw. ...
(Date received local registrar) (Registrar's signature)

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.....

Not Embalmed

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Wm A. Schuyler

Licensed Embalmer No..... *3089*

P. O. Address..... *150 7th*

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.