V. S. No. 2
OM—8-43
ev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26450

FILED SEP 10 1945

Registration District No. 109 Primary Registration District No. 1002 Registrar's No. 3613

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: General Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8/27/45 / 8/29/45 30 (Specify whether
In this community Do not know
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 48

(a) State Mo (b) County Jackson
(c) City or town Kansas City Mo 3
(If outside city or town limits, write "RURAL")
(d) Street No. 903½ Mulberry 8
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No) 0
If yes, name country no

3. (a) PRINT FULL NAME William Heffernan

3. (b) If veteran, name war Do not know
3. (c) Social Security No. Do not know

4. Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced Do not know
6. (b) Name of husband or wife Do not know
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased (Month) (Day) 1880 (Year)

8. AGE: Years 65 | Months — | Days — | If less than one day — hr. — min.

9. Birthplace Do not know (City, town, or county) 9 (State or foreign country)
10. Usual occupation Know
11. Industry or business
FATHER
12. Name Do
13. Birthplace Do not (City, town, or county) 9 (State or foreign country)
MOTHER
14. Maiden name
15. Birthplace Know (City, town, or county) 9 (State or foreign country)
16. (a) Informant Coroner Office
(b) Address Kansas City Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/31/45 (Month) (Day) (Year)
(c) Place: burial or cremation Mt Calvary K. C. K.
18. (a) Signature of funeral director Passantino Bros
(b) Address Kansas City Mo
19. (a) 8-30-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 2930
year 1945 hour minute M.
21. I hereby certify that I attended the deceased from Deputy Coroner, 19 to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Dilation of Heart
Due to Fr R. Hep
Due to Fall in home
Other conditions Senility
(Include pregnancy within 3 months of death) 186a-5
Major findings: Of operations no op 18
Of autopsy no 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) accident
(b) Date of occurrence 8/27/45
(c) Where did injury occur? Kansas City Jackson Mo 123 (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? home (Specify type of place)
While at work? no (e) Means of injury Fall
23. Signature J H Oliver (M. D. or other)
Address Kans C Mo Date signed 8/30/45

(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 Frances Walton

Licensed Embalmer No. 2744

P. O. Address K. C. 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.