

FILED AUG 22 1945

Registration District No. 149 Primary Registration District No. 1002

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 8 days
(Specify whether)
 In this community 2.5 years
(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. 2224 Indiana
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Thomas McNamara

3. (b) If veteran, name war MO **3. (c) Social Security** No. 499-16-8341

4. Sex Male **5. Color or race** Wh **6. (a) Single** **widowed, married,** **divorced**

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

7. Birth date of deceased Jan-26-1901
(Month) (Day) (Year)

8. AGE: Years 44 Months 6 Days 14 If less than one day _____ hr. _____ min.

9. Birthplace Kansas City Mo 0
(City, town, or county) (State or foreign country)

10. Usual occupation Operator

11. Industry or business James M.C. Nomara

12. Name Geloid 4

13. Birthplace Irish 4
(City, town, or county) (State or foreign country)

14. Maiden name Bridget Brodrick

15. Birthplace Irish 4
(City, town, or county) (State or foreign country)

16. (a) Informant John McNamara
(b) Address 2014 Monroe

17. (a) Burial buried **(b) Date thereof** Aug-13-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Melody M.C. Kelley
(b) Address 1100 Linwood

19. (a) Date received local registrar 8-11-45 **(b) Registrar's signature** Geraldine Holmes

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 10
 year 1945 hour 5 minute 35 P.M.

21. I hereby certify that I attended the deceased from August 2, 1945 to August 10, 1945
 that I last saw him alive on August 10, 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis

Due to _____

Due to _____

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

Major findings: _____
 Of operations _____

Of autopsy See above

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? _____

23. Signature Clark W. Seelig **(M. D. of other)** _____
Address Med. Dir. Gen'l Hosp **Date signed** 8-11-45

Duration _____
PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

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

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.