

V. S. No. 2
100M-5-43
Rev. 5-17-39
I X36671

FILED SEP 20 1945

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3735

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

1. PLACE OF DEATH: Jackson

(a) County: Jackson

(b) City or town: Kansas City

(c) Name of hospital or institution: St. Mary's Hospital 0

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

(d) Length of stay: In hospital or institution: 6 hours (Specify whether years, months or days)

In this community: 6 hours (Specify whether years, months or days)

3. (a) PRINT FULL NAME: Infant Daughter of Mr. & Mrs. Robert Byron O'Gorman

3. (b) If veteran, name war: XX

3. (c) Social Security No.: XX

4. Sex: Fe / 5. Color or race: Wh

6. (a) Single, widowed, married, divorced: Sgl 0

6. (b) Name of husband or wife: XX

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

7. Birth date of deceased: September 7 1945 (Month) (Day) (Year)

8. AGE: Years 0 Months 0 Days 0 If less than one day 6 hr. min.

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

10. Usual occupation: XX

11. Industry or business: XX

MOTHER FATHER { 12. Name: Robert Byron O'Gorman

13. Birthplace: Colorado Spgs Colorado (City, town, or county) (State or foreign country)

14. Maiden name: Mary Margaret Cain

15. Birthplace: Stanbury Missouri (City, town, or county) (State or foreign country)

16. (a) Informant: Robt. Byron O'Gorman

(b) Address: 511 West 32d St.

17. (a) Burial, cremation, or removal: Burial (b) Date thereof: 9-8-45 (Month) (Day) (Year)

(c) Place: burial or cremation: Calvary Cemetery

18. (a) Signature of funeral director: J.M. Wagner

(b) Address: Kansas City, Mo.

19. (a) 9-8-45 (Data received local registrar)

(b) [Signature] (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson 48

(c) City or town: Kansas City 3

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

(d) Street No.: 511 West 32d St. 8

(If rural, give location)

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

If yes, name country: _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. 7th day 7th

year 1945 hour 3:00 minute P. M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Pathologist

Immediate cause of death: Acute Pulmonary Congestion. Prematurity

Due to: _____

Due to: _____

Other conditions (Include pregnancy within 3 months of death): 159

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? _____

While at work? _____ (Specify type of place)

(a) Means of injury: _____

23. Signature: A.E. [Signature] (M.D. or other)

Address: 2850 Main Date signed: 9/10/45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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..... *Cecil R. Matthes*

Licensed Embalmer No. *3807*

P. O. Address *Kansas City, 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.