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

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED OCT 23 1945

State File No. 32615

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4162

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: 3925 Harrison St. 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 32 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 3925 Harrison St. 8
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Miss Nellie Q. Cosgriff

3. (b) If veteran, name war No

3. (c) Social Security No. none

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife

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

7. Birth date of deceased April 13, 1875
(Month) (Day) (Year)

8. AGE: Years 70 Months 5 Days 24 If less than one day hr. min.

9. Birthplace Ontario, Canada 2
(City, town, or county) (State or foreign country)

10. Usual occupation Retired School Teacher

11. Industry or business K.C.Mo. Schools

FATHER
12. Name Patrick Cosgriff
13. Birthplace Ireland 7
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Sarah Clark
15. Birthplace Ontario, Canada 2
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Sara A. Cosgriff
(b) Address 3925 Harrison St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 10. 1945
(Month) (Day) (Year)
(c) Place: burial or cremation St. John's K.C.K.

18. (a) Signature of funeral director Thos. E. Quirk
(b) Address 4316 Troost Ave.

19. (a) 10-10-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 7th
year 1945 hour 10.20 A.M. minutes M.

21. I hereby certify that I attended the deceased from
, 1939, to Oct., 1945;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinomatosis — Duration 6 yrs.

Due to Primary site - breast

Due to

Other conditions
(Include pregnancy within 3 months of death)
50

Major findings:
Of operations

Of autopsy

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 0

23. Signature John O Skinner (M. D. ~~or other~~)
Address 1402 Bryant Bldg. Date signed 10-8-45

(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 Thomas E. Lurk

Licensed Embalmer No. 3775

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.