

FILED DEC 6 1945
Registration District No. 149

Primary Registration District No. 1002

State File No. _____
Registrar's No. 4829

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

48
3
8

1. PLACE OF DEATH Jackson

(a) County Kansas City

(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 4030 Troost Ave. /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 16 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. 4030 Troost Ave. 8
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No) 1
If yes, name country _____

3. (a) PRINT FULL NAME Michael J. Lavery

3. (b) If veteran, No name war. 3. (c) Social Security No. None

4. Sex Male 0 5. Color or race white 6. (a) Single, widowed, married, divorced, widower

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

7. Birth date of deceased August 2, 1867 (Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 23rd year 1945 hour 9.25 A.M.

21. I hereby certify that I attended the deceased from April 15, 1945 to Nov 23, 1945 that I last saw him alive on Nov 22, 1945 and that death occurred on the date and hour stated above.

8. AGE: Years 78 Months 3 Days 21 If less than one day hr. min.

9. Birthplace Scotland 4 (City, town, or county) (State or foreign country)

10. Usual occupation Retired Watchman

11. Industry or business Hogue Mercantile Co.

12. Name John Lavery

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

14. Maiden name Ann McLean

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

Immediate cause of death Carcinoma of Prostate Gland & Rectum 5 Mo.

Due to Carcinoma of Prostate & Rectum 1 1/2 yrs

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 51 8

Of autopsy _____

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

MOTHER FATHER {

16. (a) Informant Mrs Arthur J. Saburn
(b) Address 4030 Troost Ave.

17. (a) Burial (b) Date thereof Nov. 26, 1945 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Calvary A.C.K.

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

19. (a) 11-24-45 (b) Geraldine Holmes (Date received local registrar) (Registrar's signature)

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 work) (c) Means of injury

23. Signature J. M. L. Lavery M.D. (M. D. or other) _____
Address 3880 E 27, KCMO Date signed 11-23-45

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.....

.....
working under my personal supervision.

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

Signed.....
Thomas E. Leunk

Licensed Embalmer No. *3775*

P. O. Address.....
R. E. 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.