

v. S. No. 2
00M-5-43
Rev. 5-17-39
I X36671

FILED JAN 19 1946
Registration District No. 199

Primary Registration District No. 1002

Registrar's No. **5303**

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

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 3 1/2 months
(Specify whether
14 years years, months or days)

3. (a) PRINT FULL NAME Friday Nolan

3. (b) If veteran, name war Unknown

3. (c) Social Security No. not known

4. Sex male

5. Color or race white

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

6. (b) Name of husband or wife Unknown

6. (c) Age of husband or wife if alive 16 years
(Month) (Day) (Year)

7. Birth date of deceased Feb 16 1872
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>73</u>	<u>9</u>	<u>29</u>	hr. min.

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

10. Usual occupation Unknown

11. Industry or business Unknown

MOTHER FATHER {

12. Name Unknown

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

14. Maiden name Unknown

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

16. (a) Informant Little Sisters Of the Poor

(b) Address 5331 Highland

17. (a) burial
(Burial, cremation, or removal)

(b) Date thereof 12-18-45
(Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's Cemetery

18. (a) Signature of funeral director 20 West Linwood

(b) Address 20 West Linwood

19. (a) 12-22-45
(Date received local registrar)

(b) Geraldine Holmes
(Registrar's signature)

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. 5331 Highland
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 15th
year 1945 hour 10 minute 02 A. M.

21. I hereby certify that I attended the deceased from 8-30-45 to 12-15-45
that I last saw him alive on 12-15-45
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral vascular hemorrhage

Due to _____

Due to _____

Other conditions 83a
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy None

PHYSICIAN
_____ Duration
_____ 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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature Clark W. Seligson
Address Med. Dir. K.C. Gen. Hospital

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.