

FILED JAN 21 1946

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 57

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1071

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: St. Joseph Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 12 hrs.  
In this community 12 hrs.  
years, months or days (Specify whether)

3. (a) PRINT FULL NAME William Kelly  
3. (b) If veteran, name war no  
3. (c) Social Security No. none

4. Sex male  
5. Color or race white  
6. (a) Single, widowed, married, divorced unk  
6. (b) Name of husband or wife unknown  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased unk  
(Month) (Day) (Year)

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

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

10. Usual occupation farmer

11. Industry or business \_\_\_\_\_  
12. Name Jerry Kelly  
13. Birthplace Ireland  
(City, town, or county) (State or foreign country)  
14. Maiden name Margaret Sullivan  
15. Birthplace Ireland  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Adams, neice  
(b) Address Higginsville, Mo.  
17. (a) removal (b) Date thereof 1-5-46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Higginsville, Mo.

18. (a) Signature of funeral director C. G. Meinershagen  
(b) Address Higginsville, Mo.

19. (a) 1-5-46 (b) E. Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Lafayette  
(c) City or town Higginsville  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 5  
year 1946 hour 10 minute 050 M.

21. I hereby certify that I attended the deceased from Jan. 5 1946 to \_\_\_\_\_ 19\_\_\_\_;  
that I last saw him alive on Jan. 8 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 2 days

Due to Essential arterial hypertension

Due to Generalized arterio-sclerosis years

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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? \_\_\_\_\_

23. Signature \_\_\_\_\_ (Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (a) Means of injury \_\_\_\_\_  
Date signed 1-8-46

FEB 27 1946

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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.**