S. No. 2
M—9-4-41
v. 5-17-39
I X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 8 1946

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 4668

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 152

1. PLACE OF DEATH:

(a) County: Buchanan

(b) City ~~or town~~: St. Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hospital No. 2. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 yrs. 6 mo. 2 days (Specify whether years, months or days)

In this community 2 yrs, 6 mos. 2 days

2. USUAL RESIDENCE OF DECEASED:

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

(c) ~~City~~ or town: Independence
(If outside city or town limits, write "RURAL")

(d) Street No.: County House
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME: JAMES MOYLAN.

3. (b) If veteran, name war: none

3. (c) Social Security No.: none

4. Sex: Male

5. Color or race: White

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

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

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

7. Birth date of deceased: 4 - 18 - 1878 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
67	9	15	hr. min.

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

10. Usual occupation: Common Laborer

11. Industry or business: Common Labor

FATHER
12. Name: John Moylan
13. Birthplace: Unknown (City, town, or county) Ireland (State or foreign country)

MOTHER
14. Maiden name: Catherine Fogarty
15. Birthplace: Unknown (City, town, or county) Ireland (State or foreign country)

16. (a) Informant: Mrs. Edd Nally

(b) Address: 1247 Homer Ave. K.C. Kansas

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 2 - 5 - 46 (Month) (Day) (Year)

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

18. (a) Signature of funeral director: Quirk & Tobin

(b) Address: 20 W. Linwood K.C. Mo.

19. (a) Feb. 5, 1946 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 3 year 1946 hour 1 minute 20 P. M.

21. I hereby certify that I attended the deceased from 10 - 4 - 1945 to 2 - 3 - 1946 that I last saw him alive on 2 - 3 - 1946 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Uremia	5 days
Due to: Prostatic obstruction	3 days
Due to:	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy 1322	

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

23. Signature: J. H. Morrow (M. D. ~~or other~~)

Address: State Hospital No. 2 Date signed 2/3/46.

(Licensed Embalmer's Statement on Reverse Side) St. Joseph, Mo.

3692

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

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 Charles M. Quirk

Licensed Embalmer No. 3774

P. O. Address Tx 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.