

No. 2  
M-5-43  
7-5-17-39  
I X36671

**FILED** MAY 6 1946

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1928

**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 1  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 4 Months  
(Specify whether  
 In this community 44 years  
years, months or days)

**3. (a) PRINT FULL NAME** MRS. ~~MARY~~ MARY AGNES WALSH  
 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 Married  
 6. (b) Name of husband or wife William Walsh  
 6. (c) Age of husband or wife if alive 78 years  
 7. Birth date of deceased May ? 1876  
(Month) (Day) (Year)

**8. AGE:** Years Months Days If less than one day  
69 11 - hr. min.

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

10. Usual occupation Housewife

11. Industry or business

**MOTHER FATHER**  
 12. Name Martin Dolan  
 13. Birthplace Ireland 4  
(City, town, or county) (State or foreign country)  
 14. Maiden name Mary Kennedy  
 15. Birthplace Ireland 4  
(City, town, or county) (State or foreign country)

16. (a) Informant William Walsh  
 (b) Address 2604 Madison

17. (a) Burial (b) Date thereof 4/27/46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation St. Mary's Cemetery

18. (a) Signature of funeral director Frank J. O'Brien  
 (b) Address 20 West Linwood

19. (a) 4-25-46 (b) Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Jackson 48  
 (c) City or town Kansas City 3  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 2604 Madison 8  
(If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month April day 24  
 year 1946 hour 4 minute A.M.  
 21. I hereby certify that I attended the deceased from April 1, 1946, to April 24, 1946,  
 that I last saw h. alive on April 23, 1946,  
 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Bronchopneumonia 3 days  
 Due to Myocarditis years  
Diabetic Nephritis years  
 Other conditions:  
(Include pregnancy within 3 months of death)

**PHYSICIAN**  
 Major findings:  
 Of operations no 61  
 Of autopsy no

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) (c) Means of injury MI  
 23. Signature John T. Spencer (M. D. or other) MD  
 Address 1102 E. ... Date signed 4-24-46  
F. E. M.

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

129921

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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..... *Howard W. Farmer* .....

Licensed Embalmer No. *4134* .....

P. O. Address..... *Kansas City 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.**