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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 12 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33814**
Registrar's No. **4573**

Registration District No. **149** Primary Registration District No. **1002**

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:
6046 Brookside Boulevard
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **no.** (Specify whether
In this community **4 years**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jackson, 45**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **6046 Brookside Boulevard,**
(If rural, give location)
(e) Citizen of foreign country? **no.** (Yes or No)
If yes, name country **X**

3. (a) PRINT FULL NAME **Miss Abbie A. Tobin**
3. (b) If veteran, **no.** name war
3. (c) Social Security No. **no.**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **October** day **29**
year **1946** hour **6:20** minute **A.** M.
21. I hereby certify that I attended the deceased from **Oct. 18,**
1946, to **Oct. 29,** 1946.
that I last saw her alive on **Oct. 28,** 1946
and that death occurred on the date and hour stated above.

4. Sex **female** 5. Color or race **white**
6. (a) Single, widowed, married, divorced **single**
6. (b) Name of husband or wife **X** 6. (c) Age of husband or wife if
alive **X** years
7. Birth date of deceased: **November 15 1860**
(Month) (Day) (Year)

Immediate cause of death
hemorrhage from bladder Duration **1 day**
Due to **Uremia** **6 day**
Due to **chronic vascular nephritis** ?
Other conditions **cerebral thrombosis** **15 days**
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day
85 11 14 hr. min.

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

10. Usual occupation **at home**

11. Industry or business **X**

MOTHER FATHER
12. Name **Michael Tobin** **4**
13. Birthplace **Ireland** **1**
(City, town, or county) (State or foreign country)
14. Maiden name **Hannah McCarthy**
15. Birthplace **Ireland** **4**
(City, town, or county) (State or foreign country)

PHYSICIAN
Major findings:
Of operations **131a**
Of autopsy
Underline the cause to which death should be charged statistically.

16. (a) Informant **Mrs. Madelaide S. Riley**

(b) Address **6046 Brookside, Kansas City, Mo.**

17. (c) **burial** (b) Date thereof **10-31-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Stine & McClure**

(b) Address **3235 Gillham Plaza, K. C., Mo.**

19. (a) **10-30-46** (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 place) (b) Means of injury
Signature **S. Reid Jones** (M. D. or other) **M. D.**
Address **1107 Bryan Alley** Date signed **10/29/46**

Dr. T. R. Jones

Bray and Bliley

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..... *Robert H Reed*

Licensed Embalmer No..... *3746*

P. O. Address..... *P.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.