

FILED FEB 24 1947

Registration District No. 42

Primary Registration District No. 1000

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

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. 803 Cleveland
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country *

3. (a) PRINT FULL NAME ALBERT REARDON

3. (b) If veteran, name war None 3. (c) Social Security No. Not stated

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Walter Reardon 6. (c) Age of husband or wife if alive Unknown years
7. Birth date of deceased 12-2-1879
(Month) (Day) (Year)

8. AGE: Years 67 Months 2 Days 13 If less than one day hr. min.

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

10. Usual occupation Barber

11. Industry or business Barber

MOTHER FATHER
12. Name Michael Reardon
13. Birthplace Unknown Ireland
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Helga O'Connor Reardon

(b) Address 803 Cleveland St. K.C. Mo.

17. (a) Removal Removal (b) Date thereof Feb. 16, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Plattsburg, Missouri

18. (a) Signature of funeral director Herman W. Sidenfaden

(b) Address 1802 Union St. St. Joseph, Mo.

19. (a) 2-19-47 (b) G. B. Jenkins
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 15
year 1947 hour 1 minute 30 P.M.

21. I hereby certify that I attended the deceased from 1-15-1947 to 2-15-1947
that I last saw him live on 2-15-1947
and that death occurred on the date and hour stated above.

Immediate cause of death myocarditis
Duration 10 years

Due to arteriosclerosis 20 years

Due to chronic alcoholism 35 years

Other conditions Waxoline addict 3 years
(Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy 97

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? _____

While at work? (Specify type of place) (e) Means of injury _____

23. Signature Forest Thomas (M. D. or other) _____
Address State Hospital No. 2 Date signed 2-15-47

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

Thurmon

Licensed Embalmer No.

2640

P. O. Address

St Joseph 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.