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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9019**
Registrar's No. **1159**

FILED MAR 25 1947
Registration District No. **1779**

Primary Registration District No. **1002**

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'S HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **26 DAYS**
(Specify whether years, months or days)
In this community **64 YEARS**

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. **600 HUNTINGTON ROAD**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **CORNELIUS DUNN DOLAN**
(b) If veteran, name war **no**
(c) Social Security No. **none**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **March** day **11** year **1947** hour **6** minute **55 P.M.**
21. I hereby certify that I attended the deceased from **1928** to **3-11-47**
that I last saw him alive on **March 11** and that death occurred on the date and hour stated above.

4. Sex **MALE**
5. Color or race **WHITE**
6. (a) Single, widowed, married, divorced **SINGLE**
6. (c) Age of husband or wife if alive _____ years

Immediate cause of death **Acute Cardiac failure**
Due to **Coronary artery disease**
Due to **C. interstitial to heart**
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: **5/8**
Of operations _____
Of autopsy _____

7. Birth date of deceased **AUGUST 15 1879**
(Month) (Day) (Year)

Duration **1 year**
Underline the cause to which death should be charged statistically.

8. AGE: Years **67** Months **6** Days **24 1/2**
If less than one day hr. min.

9. Birthplace **OSWEGO NEW YORK**
(City, town, or county) (State or foreign country)

10. Usual occupation **DEPUTY COLLECTOR--INTERNAL REVENUE--FEDERAL BUILDING**

11. Industry or business _____

12. Name **PETER DOLAN**
13. Birthplace **OSWEGO NEW YORK**
(City, town, or county) (State or foreign country)

14. Maiden name **MARY DUNN**
15. Birthplace **OSWEGO NEW YORK**
(City, town, or county) (State or foreign country)

16. (a) Informant **NONA K. O'DONNELL**
(b) Address **3256 BROADWAY**

17. (a) **BURIAL** (b) Date thereof **3-15-47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **MT. ST. MARY'S CEMETERY**

18. (a) Signature of funeral director **J. J. O'Donnell**
(b) Address **3256 BROADWAY**

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) Means of injury **0**
23. Signature **John T. Holmes** (M. D. or other) **MD**
Address **1169 Broadway** Date signed **3-14-47**

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.