

**FILED MAY 20 1947**  
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:  
Trinity Lutheran  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 weeks.  
(Specify whether years, months or days)

In this community 24 yrs.

**3. (a) PRINT FULL NAME** John Henry Connors

3. (b) If veteran, name war no

3. (c) Social Security No. 495-05-0282

4. Sex Male 5. Color or race Wh

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

6. (b) Name of husband or wife Eulalia Connors

6. (c) Age of husband or wife if alive 42 years

7. Birth date of deceased 8 20 1897  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
<u>49</u>	<u>8</u>	<u>14</u>	hr. min.

9. Birthplace Cambridge, Mass.  
(City, town, or county) (State or foreign country)

10. Usual occupation Painter

11. Industry or business T. W. A.

12. Name Jermiah Connors

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

14. Maiden name Mary

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

16. (a) Informant Mrs. Eulalia Connors

(b) Address 6422 E. 16th St.,

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/7/47  
(Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park, K. C. Kans

18. (a) Signature of funeral director John P. Sheil

(b) Address K. C. Mo.

19. (a) 15-5-47 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Mo (b) County Jackson

(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")

(d) Street No. 6422 E 16th St.,  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month May day 4  
year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from March 7, 1947 to May 3, 1947  
that I last saw him alive on May 3, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Coronary Infarct

Duration 2 mo

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

**PHYSICIAN**  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: no

(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 0

23. Signature Clay Nelson (M. D. or other)  
Address 3626 Independence Date signed 5-9-47

SEP 8 1947

---

---

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 John P. Shul  
Licensed Embalmer No. 3625  
P. O. Address L. C. Ho

**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.**