

S. No. 2
DM-5-43
v. 5-17-39
I X36871

21068

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUN 17 1947

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 2405

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: MEMORIAL HOSPITAL 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 HOURS
(Specify whether)

In this community 1 YEAR
(years, months or days)

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. 7601 OAK STREET 8
(If rural, give location)

(e) Citizen of foreign country? No 0 (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME YONA MARIE MAHONEY

3. (b) If veteran, name war NO

3. (c) Social Security No. NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAY day 31st
year 1947 hour 11 minute 20 P.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

4. Sex FEMALE

5. Color or race WHITE

6. (e) Single, widowed, married, divorced SINGLE

6. (b) Name of husband or wife _____

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

7. Birth date of deceased SEPTEMBER 22 1945
(Month) (Day) (Year)

Immediate cause of death

Due to Shock

Due to Skull Fracture

Due to Auto Trauma - pedestrian hit by car in drive way

Other conditions Deputy Towne way

Major findings: Of operations 170c

Of autopsy History

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

8. AGE: Years Months Days If less than one day

| | | | |
|---|---|---|----------|
| 1 | 8 | 9 | hr. min. |
|---|---|---|----------|

9. Birthplace KANSAS CITY - MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation INFANT

MOTHER FATHER

11. Industry or business _____

12. Name JOHN R. MAHONEY 1

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

14. Maiden name MARY FRANCES DIX

15. Birthplace KANSAS CITY MISSOURI
(City, town, or county) (State or foreign country)

16. (a) Informant MR JOHN R. MAHONEY

(b) Address 7601 OAK STREET

17. (a) BURIAL (b) Date thereof JUNE 3 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY CEMETERY

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident 123

(b) Date of occurrence 5/31/47

(c) Where did injury occur? Kansas City Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

18. (a) Signature of funeral director Dr. Newcomer's home

(b) Address 1401 BRUSH CREEK BLYD

19. (a) 6-2-47 (b) Shiraldine Holmes
(Date received local registrar) (Registrar's signature)

While at work? No (Specify type of place)

(c) Means of injury Trauma

23. Signature A.E. Usher (M. D. or other) MO
Address 2800 1st Main Date 6/2/47

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.....

D. D. Nofsinger

Licensed Embalmer No. *3958*

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.