

S. No. 2
1-12-45
5-17-39
X47070

STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26852

FILED SEP 8 1947

Registration District No. 2 Primary Registration District No. 1000 Registrar's No. 1045

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

at the age of sixteen years, but have no date of birth.

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 48 yrs 11 mo 13 days
(Specify whether in this community 48 yrs 11 mo 13 days years, months or days)

3. (a) PRINT FULL NAME John Mahoney

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex male 5. Color or race white 6. (a) 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 about 1882
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>65</u>			hr min.

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

10. Usual occupation none Laborer

11. Industry or business _____

MOTHER FATHER

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant Terrence Mahoney, not given

(b) Address 2417 Mercer Kansas City Mo

17. (a) Removal (b) Date thereof 8-6-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kirksville College of Osteopathy

18. (a) Signature of funeral director Lawrence

(b) Address 5025 King Hill

19. (a) 9-3-47 (b) E. G. Hopkins
(Date received local registrar) (Registrar 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. 2417 Mercer 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 Aug day 3 year 1947 hour 6 minute 45 A. M.

21. I hereby certify that I attended the deceased from July 1, 1947, to Aug 3, 1947, that I last saw him alive on Aug 2, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death 6 chronic Myocardial

Due to Arterio Sclerosis

Due to _____

Other conditions 2
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy 938

Duration _____

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? U

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

23. Signature Tommas Thorne (M. D. or other) _____

Address St Joseph Mo Date signed 8/3

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: *Emmanuel*

Licensed Embalmer No. 4285

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.