No. 2
-1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 38071

FILED DEC 9 1947

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 5005

WRITE PLAINLY—USING 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 4117 Virginia Ave.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ~~one week~~ (Specify whether
In this community one week
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL") 8

(d) Street No. 4117 Virginia
(If rural, give location)

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

If yes, name country 10

3. (a) PRINT FULL NAME James Connor

3. (b) If veteran, name war ---- no

3. (c) Social Security No. none

4. Sex Male 0

5. Color or race White

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Oct. 29, 1947
(Month) (Day) (Year)

8. AGE: Years | Months | Days 2D | If less than one day 5 weeks min.

9. Birthplace St. Paul, Minn. 1
(City, town, or county) (State or foreign country)

10. Usual occupation infant

11. Industry or business

FATHER
12. Name Frank Ireland
13. Birthplace No record 9
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Lallie Connor
15. Birthplace K.C. Kansas 1
(City, town, or county) (State or foreign country)

16. (a) Informant Lallie Connor
(b) Address 4117 Viriginia

17. (a) Burial (b) Date thereof Nov. 29, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park K.C. Mo.

18. (a) Signature of funeral director Thos. E. Quirk
(b) Address 4316 Troost Ave.

19. (a) 11-29-47 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 19th
year 1947 hour 9.30 A.M. minute M.

21. I hereby certify that I attended the deceased from Corona, 19 to 19;
that I last saw h alive on 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bronchopneumonia	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 107

Of autopsy yes - as above

#

PHYSICIAN

Underline the cause of 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? (Specify type of place)

While at work? (e) Means of injury 3

23. Signature [signature] (M. D. ~~or other~~) Corona

Address 1924 [illegible] Date signed 11-29-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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. 3775

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.