No. 300
—10-47
5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 4 1948

Registration District No. 149

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 26454

Registrar's No. 3373

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 7 WEEKS (Specify whether
In this community 10 YEARS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON 48

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

(d) Street No. 207 WEST LINWOOD
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME SISTER MARY SUSANNE MC CUE

3. (b) If veteran, name war no

3. (c) Social Security No. NONE

4. Sex FEMALE

5. Color or race WHITE

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

6. (b) Name of husband or wife

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

7. Birth date of deceased unknown (Month) (Day) (Year)

8. AGE: 86 Years | Months | Days | If less than one day hr. min.

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

10. Usual occupation RELIGIOUS

11. Industry or business

FATHER
12. Name Mc Cue 9
13. Birthplace (City, town, or county) unknown (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) 9 (State or foreign country)

16. (a) Informant MOTHER ALPHONSE MARIE.

(b) Address 207 WEST LINWOOD

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-19-48 (Month) (Day) (Year)

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

18. (a) Signature of funeral director J. F. O'Donnell

(b) Address 3256 BROADWAY

19. (a) 8-18-48 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUGUST day 17th. year 1948 hour 4 minute 10 P. M.

21. I hereby certify that I attended the deceased from July 1st, 1948, to Aug 17th, 1948 that I last saw her alive on Aug 17th, 1948 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hypertensive Heart Disease	3 yrs
Arteriosclerosis	
Due to Fracture Left Femur	7/1/48
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations 186 a	
Of autopsy 18	

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) accident

(b) Date of occurrence July 1, 1948 123

(c) Where did injury occur? K.C. Jackson, Mo. (City or town) (County) (State)

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

While at work no (e) Means of injury Fall

23. Signature James D. Smith (M. D. or other)

Address 318 Prof. Bldg. K.C. Mo. Date signed 8/18/48

(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 Park G. Rowe

Licensed Embalmer No. F349

P. O. Address K C 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.