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UNITED STATES HEALTH DEPARTMENT  
STANDARD CERTIFICATE OF DEATH

36496

FILED NOV 16 1948

State File No. ....

Registration District No. 749

Primary Registration District No. 1002

Registrar's No. 4330

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:  
General Hospital No. 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 days  
(Specify whether years, months or days)

In this community 50 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 308 No. Quincy  
(If rural, give location)

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

If yes, name country.....

3. (a) PRINT FULL NAME Frank Donegan

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Millie

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased Oct. 15 1879  
(Month) (Day) (Year)

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

69 -0 8 hr. min.

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

10. Usual occupation Retired

11. Industry or business

MOTHER FATHER { 12. Name John Donegan

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

14. Maiden name Margaret Schanhan

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

16. (a) Informant Mrs Millie Donegan

(b) Address 308 N. Quincy

17. (a) Burial (b) Date thereof Oct. 25, 48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cem.

18. (a) Signature of funeral director Quinn Tobin Co.

(b) Address 20 W. Linwood

19. (a) 10-25-48 (b) Aldredine Holmes  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 23  
year 1948 hour 4 minute 35 A.M.

21. I hereby certify that I attended the deceased from Oct. 19, 1948, to Oct. 23, 1948, that I last saw him alive on Oct. 23, 1948, and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive heart disease with pulmonary and cerebral edema

Due to.....

Due to.....

Other conditions 93d  
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: See above

Of operations.....

Of autopsy.....

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?.....

While at work? Wm. W. Hart (Specify type of place) (e) Means of injury 0

23. Signature Wm. W. Hart (M. D. or other) 10-23-48  
Address Med. Dir. Gen'l Hosp. Date signed

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

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..... Howard W. Farmer.....

Licensed Embalmer No. 4134.....

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.**