

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18049

State File No. _____

2641

FILED JUN 9 1953

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE Mo. b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN Kansas City)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4426 Flora Ave.		d. STREET ADDRESS (If rural, give location) 4426 Flora Ave.	
3. NAME OF DECEASED a. (First) Patrick b. (Middle) Martin c. (Last) Halloran		4. DATE OF DEATH (Month) (Day) (Year) May 22, 1953	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 20, 1900
9. AGE (In years last birthday) 53 years		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carman	
10b. KIND OF BUSINESS OR INDUSTRY C.B. & Q.R.R.		11. BIRTHPLACE (City and State or Foreign Country) County Galway, Ireland	
11. BIRTHPLACE (City and State or Foreign Country) County Galway, Ireland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Martin Halloran		13b. MOTHER'S MAIDEN NAME Margaret Halloran (Maiden) Margaret Halloran	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No	
16. SOCIAL SECURITY NO. 707-03-8301		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs Margaret Halloran 4426 Flora	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Malignant Hypertension ANTECEDENT CAUSES Nephritis Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 yr, 3 yrs	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 3:00 PM to May 22, 1953 , that I last saw the deceased alive on May 22, 1953 , and that death occurred at 5:55 AM from the causes and on the date stated above.			
23a. SIGNATURE John O. Skinner (Degree or title)		23b. ADDRESS 402 Brynauk Pl. 5/22/53	
23c. DATE SIGNED		23d. ADDRESS	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE May 25, 1953	24c. NAME OF CEMETERY OR CREMATORY Galvary	24d. LOCATION (City, town, or county) (State) Kansas City, Mo.
DATE REC'D BY LOCAL REG. 5-23-53	REGISTRAR'S SIGNATURE Waldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Thomas E. Quirk 4316 Troost Ave.	

(Licensed Embalmer's Statement on Reverse Side)

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

300
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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 _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Student Embalmer No. _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.