

FILED AUG 3-1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22432

State File No.

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 2927

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 township) OR TOWN Kansas City

c. LENGTH OF STAY (in this city) 45 years

c. CITY OR TOWN Kansas City

d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION Little Sisters Home

STREET ADDRESS (If rural, give location) 75 5331 Highland

3750

3. NAME OF DECEASED
a. (First) Thomas b. (Middle) F. c. (Last) Tierney

4. DATE OF DEATH (Month) (Day) (Year) July 7, 1955

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single

8. DATE OF BIRTH Aug. 21, 1882

9. AGE (In years last birthday) 72 years
IF UNDER 1 YEAR: Months _____ Days _____
IF UNDER 24 HRS.: Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Policeman

10b. KIND OF BUSINESS OR INDUSTRY K.C. Mo. Police

11. BIRTHPLACE (City and State or Foreign Country) Ireland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME No record

13b. MOTHER'S MAIDEN NAME No record

14. NAME OF HUSBAND OR WIFE _____

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____

16. SOCIAL SECURITY NO. None

17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mother Ludivine-Little Sisters

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Pancreas
INTERVAL BETWEEN ONSET AND DEATH 1 year

ANTECEDENT CAUSES
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.

157X

20. AUTOPSY? YES NO

19a. DATE OF OPERATION _____

19b. MAJOR FINDINGS OF OPERATION _____

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) _____

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from 2/19, 1950 to 7/7, 1955, that I last saw the deceased alive on 7/4, 1955, and that death occurred at 9.05 P.M. from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Joseph A. Fогarty

23b. ADDRESS 2025 811 Truman Rd K.C. Mo.

23c. DATE SIGNED 7/8/55

24a. BURIAL (CREMATION) (Specify) Buried

24b. DATE July 11, 1955

24c. NAME OF CEMETERY OR CREMATORY Mt. Olivet

24d. LOCATION (City, town, or county) (State) Hickman Mills, Mo.

DATE REC'D BY LOCAL REG. 7-9-55

REGISTRAR'S SIGNATURE Neva Minshall

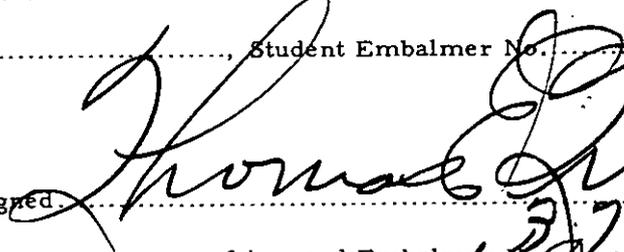
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Thos. E. Quirk 4316 Troost Ave.

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD
Joseph A. Fогarty, D.O.

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 Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....


Licensed Embalmer No.

P. O. Address.....

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

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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