

REC'D FEB 20 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1079

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
(b) Township Kaw Primary Registration District No. 100
(c) City Kansas City (d) Street No. Commonwealth Hotel St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. 922. PRINT FULL NAME Augustine Breen

(a) Residence, No. Fort Smith Arkansas St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ---6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 12, 1889

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
49 3 24

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Traveling Sales
9. Industry or business in which work was done, as saw mill, bank, etc. man
10. Date deceased last worked at this occupation (month and year) Shoe Company
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ft. Smith, Arkansas

FATHER 13. NAME William Breen
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

MOTHER 15. MAIDEN NAME Mary Bohon
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) South Carolina

17. INFORMANT (ADDRESS) Miss Bessie Breen
315 So. 13th, Ft. Smith, Ark.18. BURIAL, CREMATION, OR REMOVAL PLACE Ft. Smith, Ark. DATE Jan. 10, 193919. FUNERAL DIRECTOR (NAME) (ADDRESS) Quirk & Tobin Co.
Kansas City, Mo.20. FILED Jan 9 1939 M. M. Browne
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-6-39 19

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____.

I last saw him Deputy Coroner alive on _____, 19____. Death is said to have occurred on the date stated above, at _____, Mo.
The principal cause of death and related causes of importance were as follows:

Coronary sclerosis
Acute coronary occlusion
Acute pulmonary edema
Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.Manner of injury _____
Nature of injury _____24. Was disease or injury in any way related to occupation of deceased? YesIf so, specify _____ (Signed) Walter B. Butler, M. D.(Address) Gen Hosp: H. C. Mo.

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.....

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, above space should be left blank.