

MAR 9 1939

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

5449
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township Frank Primary Registration District No. 1002
 (c) City Kansas City (d) Street No. McClellan Hosp 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.

2. PRINT FULL NAME

(a) Residence, No. 250 Bernard Regan St.
4919 Summit (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 m
 4. COLOR OR RACE w.
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Cecilia M Regan
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 11-28 1887
 7. AGE YEARS 81 MONTHS 2 DAYS 15
 If LESS than 1 day, hrs. or min.

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

FATHER
 13. NAME John J Regan

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

MOTHER
 15. MAIDEN NAME Lucinda Burdon

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT (ADDRESS) John J Regan

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Marys DATE 2/16/39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) John J Regan

20. FILED 2/15 1939 M. M. Crowe Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-13 1939
 22. I HEREBY CERTIFY, That I attended deceased from 2-12 1939 to 2-13 1939
 I last saw him live on 2-13 1939 Death is said to have occurred on the date stated above, at 5:03 a m
 The principal cause of death and related causes of importance were as follows:

Coronary Bunches Date of onset
Pneumonia - Right 13/1
Upper and lower lobes

Other contributory causes of importance:
Chronic vasculorhe-
 phritis, Cardiac hyper-
 trophy, Chronic swelling of

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? /
 If so, specify.....

(Signed) Dr. De Maria, M. D.
St. K C Gen Hosp (Address)

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.