N. B.—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.

REC'D JUN 8 1939

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

17679
Do not use this space.

Registered No. 2081

1. PLACE OF DEATH
(a) County Jackson 2
(b) Township Kaw 1
(c) City Kansas City 1
Registration District No. 399
Primary Registration District No. 1002
(d) Street No. 4722 Terrace. 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 400 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mrs. Mary CAHILL.
(a) Residence, No. 4722 Terrace. 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: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*): Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Michael Cahill.
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Oct. 24, 1857.
7. AGE: YEARS 81 | MONTHS 6 | DAYS 22 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: At Home
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): New York. 1

FATHER
13. NAME: Thomas Fitzgerald. 5
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ireland 5

MOTHER
15. MAIDEN NAME: Elizabeth McSchain.
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ireland.

17. INFORMANT: Michael Cahill (Husband)
(ADDRESS) 4722 Terrace

18. BURIAL, CREMATION, OR REMOVAL
PLACE Lexington Mo. DATE 5/19/39. 19

19. FUNERAL DIRECTOR (NAME): Hellody-McGilley.
(ADDRESS) K. C. Mo.

20. FILED May 19, 1939 Dr. D. Brown
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 17, 1939

22. I HEREBY CERTIFY, That I attended deceased from 5-15-1939, 19..., to 5-17-, 1939
I last saw her alive on 5-15-, 1939 Death is said to have occurred on the date stated above, at ...a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Myocarditis (chronic)	
93d	

Other contributory causes of importance:
Senility
Arterio Sclerosis

Name of operation No Date of
What test confirmed diagnosis? — Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? No Date of injury —, 19...
Where did injury occur? No
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
No
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) Geo. F. Gustelson, M. D.
(Address) 932 Prof Bldg

(Licensed Embalmer's Statement on Reverse Side)

Mr. George Pendleton, V. 1020
Professional College.

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 comp with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.