

AUG 7 1939

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

24759
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
(b) Township Kaw Primary Registration District No. 1002 Registered No. 2972
(c) City or K. C. Mo. (d) Street No. St. Mary's Hospital 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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Martin Carroll Whelan

(a) Residence, No. 3115 Washington St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs. Lilly Heald Whelan
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 25, 1863
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
76 2 27
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired
9. Industry or business in which work was done, as saw mill, bank, etc. Frisco Employee
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Killarney, Ireland
(STATE OR COUNTRY)

FATHER 13. NAME Michael Whelan

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

MOTHER 15. MAIDEN NAME Mary Milan

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

17. INFORMANT Mrs. Jewell F. Keith
(ADDRESS) 3115 Washington

18. BURIAL, CREMATION, OR REMOVAL PLACE St. John's, KCK DATE July 24, 1939

19. FUNERAL DIRECTOR (NAME) John W. Wagner
(ADDRESS) Kansas City, Mo.

20. FILED 7-23-39 M. M. Crowe
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 22, 1939

22. I HEREBY CERTIFY: That I attended deceased from 1939, 19.....

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at.....12:00 Noon

The principal cause of death and related causes of importance were as follows:

Sunshot wound of the head
167
Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....
What test confirmed diagnosis..... Was there an autopsy.....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide..... Date of injury.....7/22/39

Where did injury occur? 3115 Washington, KCK
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury shot self in head
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?
If so, specify.....

(Signed) M. M. Crowe, M. D.

(Address) Kansas City, 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.