

Registration District No. **1002**
Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:
(a) County **Jackson**
(b) City or town **Kansas City Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Mary's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **47 Years**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City Mo.**
(If outside city or town limits, write "RURAL")
(d) Street No. **1212 Wabash Ave.**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? **47** years.

3. (a) PRINT FULL NAME **Mrs. Mary F. DEE.**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Sept** day **8**
year **1939** hour **5** minute **15** M.

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Michael Dee.** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Aug. 31 1870**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **9-7-39** to **9-8-39**, 19**39**, that I last saw him alive on **9-8-39**, and that death occurred on the date and hour stated above.
Immediate cause of death **Acute Gastroenteritis** Duration **4 days**

8. AGE: Years **69** Months **0** Days **7** If less than one day _____ hr. _____ min.

Due to **Do not know** 1206

9. Birthplace **County Kerry Ireland.**
(City, town, or county) (State or foreign country)

10. Usual occupation **House Wife**

11. Industry or business **At Home**

12. Name **Patrick McGillicuddy.**

13. Birthplace **Ireland**
(City, town, or county) (State or foreign country)

14. Maiden name **Margaret Sullivan**

15. Birthplace **Ireland**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Michael Dee**
(b) Address **1212 Wabash Ave**

17. (a) **Burial** (b) Date thereof **9/11/39**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **St. Mary's.**

18. (a) Signature of funeral director **Melody-McGillye.**
(b) Address **K. C. Mo.**

19. (a) **9/10/39** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: **None**
Of operations _____
Of autopsy **None**

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, or industrial place, in public place? _____

While at work? _____ (Specify type of place) (b) Means of injury _____
23. Signature **M. J. Owens** (M. D. or other) _____
Address **908 Grand Ave** Date signed **9-10-39**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rev. 5-17-39
U.S. GPO 16-10951

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.

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.