DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 42500

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 4909

JAN 2 2 1940

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. Joseph Hospital.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Day (Specify whether years, months or days)

In this community 45 Years.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 5720 Paseo
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME John B. WALSH.

3. (b) If veteran, name war World War.

3. (c) Social Security No. No

4. Sex Male

5. Color or race Whiye

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Pearl Walsh

6. (c) Age of husband or wife if alive 43 years

7. Birth date of deceased August 5th, 1889 (Month) (Day) (Year)

8. AGE: Years 50 | Months 4 | Days 22 | If less than one day ..... hr. ..... min.

9. Birthplace Chillicothe, Missouri (City, town, or county) (State or foreign country)

10. Usual occupation Owner Tire Service Co.

11. Industry or business Retail Tire Co.

FATHER
12. Name William P. Walsh
13. Birthplace Lockport Illinois (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Margaret Kennedy
15. Birthplace Frankfort Kansas (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Frank Walsh, brother

(b) Address 2545 Benton Blvd., K.C.Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/39. (Month) (Day) (Year)

(c) Place: burial or cremation St. Marys Cemetery

18. (a) Signature of funeral director Mellody - McGilley

(b) Address K. C. Mo.

19. (a) Dec. 28, 1939 (Date received local registrar) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 27 day Dec year 1939 hour 2 minute 45 A M.

21. I hereby certify that I attended the deceased from ....., 19.... to Dec 27, 1939; that I last saw him alive on Dec 26, 1939 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Carcinomatosis general of abdomen	
Due to Primary unknown	
Due to 53	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature D M Tugn (M. D. or other)

Address 525 Apple Bldg Date signed

(Licensed Embalmer's Statement on Reverse Side)

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

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.

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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. 2799

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.