

Registration District No. **399**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
K.C. General Hospital No. 1.
(If not in hospital or institution, write street number or location) **1**
(d) Length of stay: In hospital or institution **11 days**
(Specify whether
In this community **Life**
years, months or days)

3. (a) PRINT FULL NAME **IRENE E ISLER**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **No**

4. Sex **Female** 5. Color of race **Wh** 6. (a) Single, widowed, married, divorced **m**
6. (b) Name of husband or wife **Robert E. Isler** 6. (c) Age of husband or wife if alive **40** years
7. Birth date of deceased **April 3, 1902**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
38		5	4	hr. min.

9. Birthplace **Kansas City, Mo**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business

12. Name **James J. O'Neill**

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

14. Maiden name **Billy Fitzgerald**

16. Birthplace **N.Y.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Robert E. Isler**

(b) Address **5820 Forest**

17. (a) **B.** (b) Date thereof **9/9/40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Mary's Cemetery**

18. (a) Signature of funeral director **W. M. Brown**

(b) Address **20 W. ...**

19. (a) **Sept. 8, 1940** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

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. **5820 Forest**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **September** day **7th**
year **1940** hour **9** minute **50** A.M.

21. I hereby certify that I attended the deceased from **8-28-40**, 19____, to **9-7-40**, 19____;
that I last saw h. **er** alive on **9-7-40**, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Toxic psychosis and possible Addison's Disease

Due to _____

Due to **84**

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy **None**

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? _____

While at work? _____ (Specify type of place) (e) Means of injury **!**

23. Signature **Dr. R. Thon** (M. D. or other) _____

Address **Med. Dir. K.C. Gen. Hosp.** Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

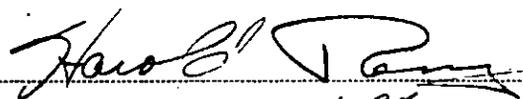
STATEMENT BY LICENSED EMBALMER

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. 4097.....

P. O. Address K C Mo.....

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.