

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **30995**
Registrar's No. **3558**

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH

Jackson
(a) County
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
918 West 33rd
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **65 years**
(Specify whether years, months or days)

8. (a) PRINT FULL NAME **THOMAS J. EAGAN**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Margaret Solan Eagan** 6. (c) Age of husband or wife if alive **63** years

7. Birth date of deceased **January 18, 1875**
(Month) (Day) (Year)

8. AGE: Years **65** Months **7** Days **21** If less than one day
hr. min.

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

10. Usual occupation **Retired**
11. Industry or business **Alton B & O RR**

MOTHER FATHER { 12. Name **Thomas Eagan**
13. Birthplace **Ireland**
(City, town, or county) (State or foreign country)
14. Maiden name **Catherine Carroll**
15. Birthplace **Ireland**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Margaret Eagan**
(b) Address **918 West 33**

17. (a) **Burial** (b) Date thereof **9/12/40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Quirk & Tabin, Cal**
(b) Address **Kansas City, Mo**

19. (a) **Sept. 11, 1940** (b) **M. M. Crowe**
(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 limit- write "RURAL")
(d) Street No. **918 West 33rd St.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **9**
year **1940** hour **4** minute **0** P. M.

21. I hereby certify that I attended the deceased from **Nov 22 - 1937**
_____, 19____, to **Sept 9**, 19____
that I last saw him alive on **Sept 9**, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death
Myocardial Exhaustion Chronic

Due to **Pyelonephritis - Left - right**

Due to **Renal injury 1937**
complicated by renal abscess

Other conditions **and Calculus of ureter**
(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?
1937 Industrial (Railroad)
While at work? **yes** (Specify type of place) (e) Means of injury **fall from car**

23. Signature **M. M. Crowe** (M. D. or other)
Address **1019 Coffey Bldg** Date signed **9/10/40**

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

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

Harold Perry

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No.

Primary Registration District No.

Registrar's No. 3558

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

1. PLACE OF DEATH:

(a) County
(b) City or town
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town
(If outside city or town limits write "RURAL")
(d) Street No.
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? years.

3. (a) PRINT FULL NAME Thomas J. Cagan

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

4. Sex 5. Color or race 6. (a) Single, widowed, married, divorced
6. (b) Name of husband or wife 6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
65 hr. min.

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

10. Usual occupation.

11. Industry or business.

12. Name.

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

14. Maiden name.

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

16. (a) Informant.

(b) Address.

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

(c) Place: burial or cremation.

18. (a) Signature of funeral director.

(b) Address.

19. (a) 9/11/40 (Date received local registrar) (b) M. M. Crome (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Sept day 9 year 1940 hour minute M.

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

Immediate cause of death Myocardial Infarction, chronic
Due to Pyelonephrosis - left
Due to Renal injury 1937
complicated by renal abscess & calculus formation
Other conditions:
(Include pregnancy within 3 months of death)

Major findings: Of operations. 93c
Of autopsy. 134a

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) acc

(b) Date of occurrence 1937

(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?

Industrial (Specify type of place)

23. Signature R. H. Hoffman (M. D. or other)

Address Date signed

SUPPLEMENTARY

5-30995