No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 12 1940

Registration District No. 399

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

34433

State File No.

Registrar's No. 3949

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

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: 5646 Lydia Ave. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 6 Yrs.
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")

0 (d) Street No. 5646 Lydia Ave.
(If rural, give location)

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

3. (a) PRINT FULL NAME Mrs. Annie GARVIN.

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Michael Garvin

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

7. Birth date of deceased May (Month) 8th (Day) 1858 (Year)

8. AGE: Years 82 Months 5 Days 6 If less than one day hr. min.

9. Birthplace (City, town, or county) Illinois (State or foreign country) 1

10. Usual occupation At Home 2

11. Industry or business 3

FATHER
12. Name Michael Gaffney
13. Birthplace (City, town, or county) Canada (State or foreign country)

MOTHER
14. Maiden name Ann Riley
15. Birthplace (City, town, or county) Ireland (State or foreign country)

16. (a) Informant Mrs. T. J. Donegan.
(b) Address 5646 Lydia. Ave.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/15/40 (Month) (Day) (Year)
(c) Place: burial or cremation Sedalia Missouri

18. (a) Signature of funeral director Mellody-McGilley
(b) Address K. C. Mo.

19. (a) 10-14-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 14th year 1940 hour 2 minute 20 A. M.

21. I hereby certify that I attended the deceased from Mo Nov 8th, 1935, to 10-14, 1940; that I last saw her alive on 10-11, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Peranchymatous nephritis chronic

Due to 131

Due to

Other conditions Hypertension
(Include pregnancy within 3 months of death)
Cerebral Hemorrhage

Major findings:
Of operations None
No Operation
Of autopsy No

Duration

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 1

23. Signature H. H. Powers (M. D. or other)

Address 1034 Rialto Bldg Date signed 10-14-40

(Licensed Embalmer's Statement on Reverse Side)

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. 267

working under my personal supervision.

Signed.....

Licensed Embalmer No. 2999

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.