

2  
0-39  
-39  
21492

LED JAN 8 1941 399

1002

Registrar's No. **5031**

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

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:  
At Home 222 West Armour Blvd  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 48 years (Specify whether  
years, months or days) 2

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. 222 West Armour Blvd  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. Eighty-Four years.

3. (a) PRINT FULL NAME Mrs Annie Carroll

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 Richard Carroll 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased April 19th, 1851  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
89 8 11 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation At Home

11. Industry or business None

12. Name John McLernon.

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

14. Maiden name Anna Brady.

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

16. (a) Informant Dr Margaret Carroll

(b) Address 222 West Armour Blvd

17. (a) Burial (b) Date thereof 1/3/41  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

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

(b) Address Kansas City Missouri

19. (a) 12-31-40 (b) h. m. Brown  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 30  
year 1940 hour 5:55 minute 50 P. M.

21. I hereby certify that I attended the deceased from Dec. 20 1940 to Dec. 30 1940  
that I last saw her alive on Dec. 30 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration \_\_\_\_\_  
Due to Senility

Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_ PHYSICIAN \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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? 3  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Sara Limbach (M. D. or other) P.O.  
Address 2603 East 31st St. Date signed 12/30/40

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

MOTHER FATHER

**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 267

....., Registered Apprentice No. ....

working under my personal supervision.

Signed.....

*W. Brown*

Licensed Embalmer No. 2999

P. O. Address..... CC

**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.**