

No. 2
1-12-40
17-39
X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

5836

MAR 14 1941

Registration District No. 299

Primary Registration District No. 1002

State File No. _____

Registrar's No. 608

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution 3211 McGee
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 60 years
years, months or days John A. Cattanach

3. (a) PRINT FULL NAME JOHN A. CATTANACH

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Delia Cattanach 6. (c) Age of husband or wife if alive 65 years
7. Birth date of deceased September 28, 1861
(Month) (Day) (Year)

8. AGE: Years 79 Months 4 Days 11 If less than one day _____ hr. _____ min.

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

10. Usual occupation Engineer

11. Industry or business Municipal Farm

12. Name Alouis Cattanach

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

14. Maiden name Anastasia Joyce

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

16. (a) Informant Mrs. Delia Cattanach
(b) Address 3211 McGee

17. (a) Burial (b) Date thereof 2/12/41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. Mary's Cemetery

18. (a) Signature of funeral director Quirk and Tobin Co.
(b) Address H. C. Co.

19. (a) 2/11/41 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL") 8
(d) Street No. 3211 McGee
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 9th
year 1941 hour 6 minute P 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 Cerebral Occlusion plurisy

Due to Cerebral occlusion plurisy
Due to fracture Rt. Hip ball
when occlusion occurred.

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Retenon. Heart's
Of operations 2 up hrs. Plurisy
Of autopsy _____

Duration _____
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) (Country) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place) _____
(a) Means of injury While at work

23. Signature Dr. John P. Brown (M. D. or other) D
Address 1402 13th St. W. W. Mo. Date signed 2/11/41

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.....

b., Registered Apprentice No.....
i working under my personal supervision.

Signed *Harold Perry*.....

Licensed Embalmer No. *4097*.....

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No.

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **608**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **3211 McGee**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME **John A. Cattanech**

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

4. Sex **Male** 5. Color or race **White** 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 **79** Months _____ Days _____ If less than one day _____ 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) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **2/11/41** (b) **M. M. Crowe**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town **Kansas City**
(If outside city or town limits write "RURAL")
(d) Street No. **3211 McGee**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

20. DATE OF DEATH Month **Feb.** day **9th**
year **1941** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from **Jan 4** 19 **41** to **Feb 9** 19 **41**
that I last saw him **alive** on **6-9-** 19 **41**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Cerebral occlusion** Duration **6 wks**

Due to **Arterio sclerosis - fracture of rt. hip when occlusion occurred**

Due to _____
Other conditions **186a**
(Include pregnancy within 3 months of death)

Major findings: **10**
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence **Jan 4, 19 41**

(c) Where did injury occur? **K 6 mo**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home

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

23. Signature **J. O. Skinner** (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTAL

MOTHER FATHER

S-5836