

Registration District No. 399

Primary Registration District No. 1007

1. PLACE OF DEATH: Jackson
 (a) County Kansas City
 (b) City or town
 (c) Name of hospital or institution: 922 Washington
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution
 In this community 50 Years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Nellie Corcoran

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

4. Sex Female
 5. Color or race White
 6. (a) Single, wife, widowed, divorced, or married

6. (b) Name of husband or wife
 6. (c) Age of husband or wife if alive

7. Birth date of deceased August 16 1880
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	60	9	29	hr. min.

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

10. Usual occupation At Home

11. Industry or business

MOTHER FATHER {
 12. Name John J. Corcoran
 13. Birthplace Ireland
 14. Maiden name Elden Judge
 15. Birthplace Ireland

16. (a) Informant Mrs J. S Perkins
 (b) Address 922 Washington

17. (a) Burial (b) Date thereof June 18-41
 (Burial, cremation, or removal) Mt St Marys
 (c) Place: burial or cremation

18. (a) Signature of funeral director J. F. O'Donnell Co.
 (b) Address 2256 Broadway, K. C., Mo.

19. (a) (Date received by registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson
 (c) City or town Kansas City
 (d) Street No. 922 Washington
 (e) If foreign born, how long in U. S. A. years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 15
 year 1941 hour 8:25 minute A. M.

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

Due to Chronic Myocarditis
 935

Other conditions (Include pregnancy within 3 months of death)
 935

Major findings:
 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
 (c) Where did injury occur?
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

28. Signature (M. D. or other)
 Address Date signed

048
 3
 8

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....

Park G. Rowe

Licensed Embalmer No.....

2347

P. O. Address.....

H. E. 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.