

FILLED SEP 12 1941
Registration District No. **379**

Primary Registration District No. **100**

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

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: **K.C. General Hospital No. 1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **5 days** (Specify whether
In this community _____
years, months or days)

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. **3330 E. 19th St. Terrace**
(If rural, give location)
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Nellie Callahan

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **June 10, 1862**
(Month) (Day) (Year)

8. AGE: Years **79** Months **1** Days **24** If less than one day hr. min.

9. Birthplace **Co. Clare, Ireland**
(City, town, or county) (State or foreign country)

10. Usual occupation **At Home**

11. Industry or business _____

MOTHER FATHER { 12. Name **Patrick Callahan**
13. Birthplace **Ireland**
(City, town, or county) (State or foreign country)
14. Maiden name **Margaret Griffin**
15. Birthplace **Ireland**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Bridget Lagan**
(b) Address **3330 East 19 Terrace**

17. (a) **Burial** (b) Date thereof **8/6/41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Mary's Cemetery**

18. (a) Signature of funeral director **Quirk & Tobin Co.**

(b) Address **217 E. 1st**

19. (a) **8/5/41** (b) **M. M. Cron**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **4th**
year **1941** hour **5** minute **30** A. M.

21. I hereby certify that I attended the deceased from **7-30-41** to **8-4-41** 19____
that I last saw her alive on **8-4-41** 19____
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Cardiac dilatation and hypertrophy
Pulmonary edema, congestion
Due to **Bronchopneumonia**

Due to _____
Other conditions (Include pregnancy within 3 months of death) **95°C**

Major findings: Of operations _____
Of autopsy **See above**

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?

While at work? _____ (Specify type of place) (c) Means of injury _____
23. Signature **Dr. R. R. Shaw** (M. D. or other) **S**
Address **Med. Dir. K.C. Gen. Hospital, K.C. Mo.** Date signed _____

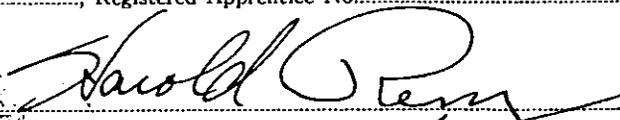
STATEMENT BY LICENSED EMBALMER

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.....



Licensed Embalmer No. 40975

P. O. Address K. C. Ma

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.