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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

DEC 22 1941

Registration District No. 397

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 37387

Registrar's No. 4182

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: St. Joseph Hospital. O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 7 Months.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 46 O

(c) City or town Independence Mo.
(If outside city or town limits, write "RURAL")

(d) Street No. RR#3 Box 706 1
(If rural, give location)

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

3. (a) PRINT FULL NAME John J. MULROONEY.

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Male O

5. Color or race White

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

6. (b) Name of husband or wife M. J. Mulrooney

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

7. Birth date of deceased February (Month) 22nd (Day) 1859 (Year)

8. AGE: Years 82 Months 8 Days 19 If less than one day ..... hr. ..... min.

9. Birthplace ..... (City, town, or county) Ireland 4 (State or foreign country)

10. Usual occupation Retired

11. Industry or business Office Man Met Inc.

FATHER
12. Name Martin Mulrooney.
13. Birthplace ..... (City, town, or county) Ireland 4 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace ..... (City, town, or county) Unknown 9 (State or foreign country)

16. (a) Informant Thomas J. Mulrooney. 1

(b) Address St. Louis Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/12/41 (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis Missouri.

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

(b) Address K. C. MO.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 11
year '41 hour 12 - minute 20 P M

21. I hereby certify that I attended the deceased from Oct 1 - 1941, to Nov 11 - 1941;
that I last saw h in alive on Nov. 11 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Failure (acute)

Due to Terminal - Bronchial Pneumonia

Due to Hypertensive Heart Disease

Other conditions 93 P
(Include pregnancy within 3 months of death)

Major findings:
Of operations no -

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 .....

23. Signature M O Hill M.D (M. D. or other)

Address 2 N Arcadia K C Mo Date signed 11-11-41

(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 the above constitutes grounds for revocation of license.)

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