

NOV 1 1943

149

Primary Registration District No. 1002

Registrar's No. 4479

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:
St. Joseph's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **About 14 hours**
(Specify whether years, months or days) **36 years**

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. **2728 Gillham Rd.**
(If rural, give location)
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME **Patrick Joseph Connors**

3. (b) If veteran, name war. **no** 3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or face **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Mary Connors** 6. (c) Age of husband or wife if alive **65** years

7. Birth date of deceased **October 1 1869**
(Month) (Day) (Year)

8. AGE: Years **74** Months **0** Days **20** If less than one day hr. min.

9. Birthplace **Lexington Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired-Formerly with Water Department**

11. Industry or business

12. Name **Dominic Connors**

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

14. Maiden name **Mary Moran**

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

16. (a) Informant **Dominic Connors**

(b) Address **2728 Gillham Rd.**

17. (a) **Burial** (b) Date thereof **10-23-43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Tipton, Mo. - St. Andrews Cemetery**

18. (a) Signature of funeral director **J. J. ...**

(b) Address **3256 Broadway**

19. (a) **10-22-43** (b) **N. E. Brown**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **21** at year **1943** hour **one** minute **25 A.M.**

21. I hereby certify that I attended the deceased from **March** 19 **42** to **Oct 20** 19 **43**; that I last saw him alive on **Oct 20** 19 **43**; and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary disease associated with acute pancreatitis + generalized arteriosclerosis**

Due to **Hypostatic Bronchial pneumonia** 36 Yrs

Other conditions **128**
(Include pregnancy within 3 months of death)

Major findings: **Acute pancreatitis**
Of operations **as above**
Of autopsy **as 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)
(a) Means of injury _____
23. Signature **Thos C. McHale** (M. D. or other) _____
Address **4620 Independence Ave** Date signed **10-21-43**

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

Signed Paul G. Rowe
Licensed Embalmer No. 2347
P. O. Address K. 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, fact should be so stated above.