

S. No. 2  
M-2-43  
5-17-39  
I X35697

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 41240  
5554  
Registrar's No.

FILED JAN 5 1949  
Registration District No.

Primary Registration District No. 1002

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

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Kansas City  
(c) Name of hospital or institution:  
Lakeside Hosp  
(d) Length of stay: In hospital or institution 1 hr 15 min  
In this community 40 yrs

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Jackson  
(c) City or town Kansas City  
(d) Street No. 523 Grand  
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME MARTIN J. REGAN  
(b) If veteran, name war no  
(c) Social Security No. none

MEDICAL CERTIFICATION  
20. DATE OF DEATH Month Oct day 25<sup>th</sup>  
year 1943 hour 5 minute 20 P.M.  
21. I hereby certify that I attended the deceased from Woman  
that I last saw him alive on 19  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race W  
6. (a) Single, widowed, married, divorced no  
(b) Name of husband or wife  
(c) Age of husband or wife if alive years  
7. Birth date of deceased unknown

Immediate cause of death Arteriosclerotic heart disease  
Due to 93d  
Due to  
Other conditions  
Major findings:  
Of operations  
Of autopsy negative

8. AGE: Years 70 yrs Months Days If less than one day

9. Birthplace Mo (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 Coroner's office  
(b) Address K.C. Mo

17. (a) Burial (b) Date thereof 1/10/49  
(c) Place: burial or cremation

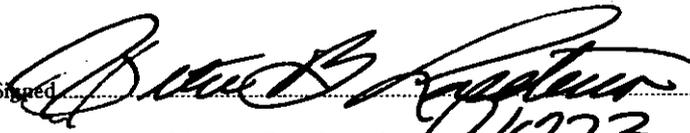
18. (a) Signature of funeral director P. E. Brown  
(b) Address  
19. (a) 12-27-43 (b) P. E. Brown  
(Date received local registrar) (Registrar's signature)

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) (e) Means of injury  
23. Signature Joseph 3 (M. D. or other)  
Address Cent Date signed 12/19/43

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. 04773  
P. O. Address KC

**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.**