

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10013**
Registrar's No. **1200**

FILED APR 6 1944
Registration District No. **21949**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2804 East 31st Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community **55 Years** years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City Missouri**
(If outside city or town limits, write "RURAL")
(d) Street No. **2804 East 31st Street**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Mrs Mary E. Moran**

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

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Ed B. Moran** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **July 1st 1865**
(Month) (Day) (Year)

8. AGE: Years **78** Months **8** Days **13** If less than one day _____ hr. _____ min.

9. Birthplace **County Mayo Ireland**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business **At Home**

MOTHER FATHER

12. Name **Michael Martin**
13. Birthplace **Unknown Ireland**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown Ireland**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr Tom Moran**
(b) Address **3216 East 28th Street**

17. (a) **Burial** (b) Date thereof **3-16-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Mellody-McGilley**
(b) Address **Kansas City Missouri**

19. (a) **3-16-44** (b) **T. E. Brown**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **14th**
year **1944** hour **10:30** minute **A.** M.

21. I hereby certify that I attended the deceased from **Nov 15**, 19**43**, to **March 14**, 19**44**
that I last saw her alive on **3/14**, 19**44**
and that death occurred on the date and hour stated above.

Immediate cause of death
**Chronic myocarditis
Pulmonary edema
Chronic nephritis
Diabetes**

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____
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 **Dr. T. E. Brown** (M. D. or other)
Address **925 Dugger St** Date signed **3/15/44**

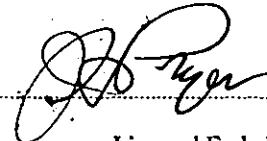
WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

Pres Oil
1000

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.....

2997
HC

P. O. Address.....

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.