V. S. No. 2
100M—5-43
Rev. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 2 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 5378

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 586

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

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: Roanoke Nursing Home "3660 Summit (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 Weeks (Specify whether

In this community 22 Years years, months or days)

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") 48

(d) Street No. 703 West 10 (If rural give location) 3

(e) Citizen of foreign country? U S A (~~Use~~ or No) 0

If yes, name country 0

3. (a) PRINT FULL NAME Thomas F. Whalen

3. (b) If veteran, name war No

3. (c) Social Security No. 703-03-8417

4. Sex Male

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 January (Month) - 17 (Day) - 1884 (Year)

8. AGE: Years 61 Months 0 Days ~~23~~ 17 If less than one day ✓ hr. ✓ min.

9. Birthplace Lansing Iowa (City, town, or county) (State or foreign country) 1

10. Usual occupation Mail handler

11. Industry or business Rail Road

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

MOTHER
14. Maiden name Ellen Donlen
15. Birthplace Bowling Green-Kentucky (City, town, or county) (State or foreign country)

16. (a) Informant Clarence A. Schutty

(b) Address 4610 East 7

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Feb 5-45 (Month) (Day) (Year)

(c) Place: burial or cremation Lansing Iowa

18. (a) Signature of funeral director A. P. Doehler

(b) Address 1415 East 15

19. (a) 2-5-45 (Date received local registrar) (b) R. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 4 year 1945 hour 6 minute 30 A.M.

21. I hereby certify that I attended the deceased from 1938, 19__, to 2-4, 1945; that I last saw him alive on 2-4, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Carcinoma Rectum	
Due to	
Due to 46 d	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations Carcinoma Rectum	PHYSICIAN
Of autopsy	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) 0

(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 [illegible] (M. D. or other) M.D.

Address 1034 Ricketts Bldg Date signed 2-5-45

(Licensed Embalmer's Statement on Reverse Side)

361

MAR - 2 1945

MAR 20 1945

MAR 29 1945

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. H P L Doehler

Licensed Embalmer No. 1166

P. O. Address. 1415 East 15

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.