

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1086

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: General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 days
In this community 20 Years
(Specify whether 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")
(d) Street No. 520 Oak
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Edward Connors

3. (b) If veteran, name war None

3. (c) Social Security No. Unknown

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 Nov. 19 1866
(Month) (Day) (Year)

8. AGE: Years 79 Months 3 Days 2 If less than one day _____ hr. _____ min.

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

10. Usual occupation Laborer

11. Industry or business

12. Name Mike Connors

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

14. Maiden name Elizabeth Liper

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

16. (a) Informant Record Clerk

(b) Address K.C. General Hosp.

17. (c) Anatomical (b) Date thereof 3-5-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kirksville, Missouri

18. (a) Signature of funeral director Weilert Funeral Home

(b) Address Kansas City, Missouri

19. (a) 3-5-46 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 21
year 1946 hour 2 minute 15 P.M.

21. I hereby certify that I attended the deceased from Feb. 13 19 46 to Feb. 21 19 46
that I last saw him alive on Feb. 21 19 46
and that death occurred on the date and hour stated above.

Immediate cause of death: Malnutrition; Lobar pneumonia

Due to _____

Due to _____

Other conditions: _____
(Include pregnancy within 5 months of death)

Major findings: _____
Of operations: _____

Of autopsy: None

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)
(c) Means of injury _____
23. Signature Clark W. Seely (M.D. or other) 2-26-46
Address Med. Dir. Gen'l Hosp. Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Dr. Ruff

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 *Blaine E. Wilett*
Licensed Embalmer No. *4075*
P. O. Address *K.C.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.