

No. 2  
-12-45  
5-17-39  
I X47070

**FILED FEB 5 1947**  
Registration District No. **147**

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  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
316 Garfield  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution no (Specify whether years, months or days)

In this community 60 yrs. (Specify whether years, months or days)

3. (a) PRINT MICHAEL FRANCIS CROWLEY  
FULL NAME

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Male

5. Color or race Wh

6. (a) Single, widowed, married, divorced, Wid.

6. (b) Name of husband or wife Anna Gooley Crowley

6. (c) Age of husband or wife if alive Dec years

7. Birth date of deceased 9/17/1862  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>84</u>	<u>4</u>	<u>68</u>	hr. min.

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

10. Usual occupation Retired Police officer  
City of Kansas City

11. Industry or business

12. Name No record

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

14. Maiden name No record

15. Birthplace No record  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Peter De Fe o

(b) Address 316 Garfield, Kansas City, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/22/47  
(Month) (Day) (Year)

(c) Place: burial or cremation Mt. Calvary

18. (a) Signature of funeral director John F. Sheil

(b) Address K Mo

19. (a) 1-20-47 (Date received local registrar) Michael Holmes (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")

(d) Street No. 316 Garfield  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 19  
year 1947 hour 2 minute P M.

21. I hereby certify that I attended the deceased from March 1-12, 1946, to Jan 19, 1947  
that I last saw h. in alive on Jan 18, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic Heart Disease & Cardiac failure

Duration 10 yrs

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 93 D

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) (c) Means of injury

23. Signature J. D. Bennett (M. D. or other) M.D.  
Address 822 Argyle Bldg Date signed 1-20-47

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**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.....

*John P. Shiel*

Licensed Embalmer No. *3625*

P. O. Address *766 M.*

**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.**