

FILED JAN 27 1947

Registration District No. 449

Primary Registration District No. 1002

Registrar's No. 209

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 18 days
(Specify whether years, months or days)

In this community Do not know
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. unknown
(If rural, give location)

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

3. (a) PRINT FULL NAME Patrick Shea

3. (b) If veteran, name war Do not know 3. (c) Social Security No. unknown

4. Sex Male 5. Color or 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 March 21 18 85
(Month) (Day) (Year)

8. AGE: Years 61 Months 9 Days 24 If less than one day hr. min.

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

10. Usual occupation Labor

11. Industry or business _____

12. Name Peter Shea

13. Birthplace Do not know
(City, town, or county) (State or foreign country)

14. Maiden name Mary Shea

15. Birthplace Do not know
(City, town, or county) (State or foreign country)

16. (a) Informant General Hospital

(b) Address K.C. Mo

17. (a) Removal (b) Date thereof 1/16/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bradford Penn

18. (a) Signature of funeral director Parmenter Bros

(b) Address K.C. Mo

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 15
year 1947 hour 4 minute 37 PM.

21. I hereby certify that I attended the deceased from Dec. 28 19 46 to Jan. 15 19 47
that I last saw him alive on Jan. 15 19 47
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis

Due to _____

Due to _____

Other conditions 1306
(Include pregnancy within 3 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? 0

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature Wm W Hart (M. D. or other) MD

Address Med. Dir. Gen'l Hosp Date signed 1-16-47

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

*P. M.
Richard*

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 *Frederic Walter*

Licensed Embalmer No. *2744*

P. O. Address *15. C. M. O.*

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.