

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

FILED APR 8 1947  
Registration District No. 749

Primary Registration District No. 1002

State File No. \_\_\_\_\_  
Registrar's No. 1468

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 11 hrs.  
(Specify whether  
 In this community 58 years  
years, months or days)

3. (a) PRINT FULL NAME Leo McGarigle  
 3. (b) If veteran, name war No  
 3. (c) Social Security No. 486-09-2761

4. Sex MALE  
 5. Color or race W  
 6. (a) Single, widowed, married, divorced MARRIED  
 6. (b) Name of husband or wife Deloy  
 6. (c) Age of husband or wife if alive 65 years  
 7. Birth date of deceased August 3 1886  
(Month) (Day) (Year)

8. AGE: Years 60 Months 7 Days 25  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation SALESMAN

11. Industry or business McAlestar Fuel Co.

12. Name Edward McGarigle

13. Birthplace No RECORD  
(City, town, or county) (State or foreign country)

14. Maiden name MARY Caffery

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

16. (a) Informant Mrs Deloy McGarigle

(b) Address 3517 Wyandotte

17. (a) Burial (b) Date thereof 3/31/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Mary's Cemetery

18. (a) Signature of funeral director Quirk + Bohner

(b) Address 20 W. Leeward

19. (a) 3-29-47 A Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

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. 3517 Wyandotte  
(If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 28  
 year 1947 hour 9 minute 40 P.M.

21. I hereby certify that I attended the deceased from March 28, 1947 to 3-28, 1947  
 that I last saw him alive on 3-28, 1947  
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebrovascular accident

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions g30  
(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? \_\_\_\_\_

While at work? \_\_\_\_\_  
(Specify type of place) (e) Means of injury

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

Address Med. Dir. Gen'l Hosp. Date signed 3-29-47

Duration \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

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

*Dr. Akers*

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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 J. Lowrey*

Licensed Embalmer No.....

*4424*

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.**