

S. No. 2  
M-5-43  
5-17-39  
I X36677

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

27613

State File No. ....

FILED JUN 19 1947

Registration District No. 199

Primary Registration District No. 1002

Registrar's No. 3358

1. PLACE OF DEATH:

(a) County Jacksaw

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

(c) Name of hospital or institution: 1639 Kensington  
(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) 20 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

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

(d) Street No. 1639 Kensington  
(If rural, give location)

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

3. (a) PRINT FULL NAME THOMAS H. BYRNE

3. (b) If veteran, name war No

3. (c) Social Security No 496-09-4653

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 6 year 1947 hour 7 minute A M.

21. I hereby certify that I attended the deceased from Coroner, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race wh.

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

6. (b) Name of husband or wife No Record

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

7. Birth date of deceased 7 9 1877  
(Month) (Day) (Year)

Immediate cause of death Coronary Thrombosis

Due to arterio sclerosis

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

Other conditions (Include pregnancy within 3 months of death) 95C

8. AGE: Years Months Days If less than one day

70	0	27	hr. min.
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Major findings: 95C

Of operations \_\_\_\_\_

Of autopsy no

History & Treatment

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

10. Usual occupation Brick Layer

11. Industry or business \_\_\_\_\_

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 Sam M. Kelly (M. D. or other) \_\_\_\_\_  
Address 1424 1/2 N. 1st Date signed 6-47

MOTHER FATHER

12. Name Thomas H. Byrne

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

14. Maiden name Mary E. Walker

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

16. (a) Informant James O. Byrne

(b) Address 11312 E 9

17. (a) Burial (b) Date thereof 8/9/47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director John P. Shier

(b) Address 66 E. 1st

19. (a) 8-8-47 (b) Steraldine Holmes  
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

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

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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. Shield*

Licensed Embalmer No. *3625*

P. O. Address *66 Md*

**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.**