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MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

40270

State File No. _____

FILED DEC 29 1948/49
Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 5023

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: K. C. General Hosp. #1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day
(Specify whether _____)

In this community 45 YEARS
(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. 923 Washington
(If rural, give location)

(e) Citizen of foreign country? UNKNOWN (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME John Mooney

3. (b) If veteran, name war No

3. (c) Social Security No. 495-03-9563

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 29th
year 1948 hour 10:25PM minute _____ M.

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 JULY 29 1895
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Person, 19____, to _____, 19____;

that I last saw h_____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

8. AGE: Years 63 Months 4 Days 0

If less than one day _____ hr. _____ min.

Immediate cause of death Fracture of Skull

Due to _____

Due to _____

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

10. Usual occupation WATCHMAN

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: _____

Of operations _____

11. Industry or business H. D. LEE COMPANY

12. Name UNKNOWN MOONEY G

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

14. Maiden name UNKNOWN

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

Of autopsy no

fracture of skull

16. (a) Informant MRS. E. M. HYDE

(b) Address 7311 VIRGINIA AVENUE

17. (a) BURIAL (b) Date thereof DEC-9-1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation FOREST HILL CEMETERY

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Do not know

(b) Date of occurrence Nov-28-48-125

(c) Where did injury occur? 100 Jackson
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? about home

18. (a) Signature of funeral director D. H. Newman

(b) Address 1401- BRUSH CREEK BLVD.

19. (a) 12-9-48 (b) Sheraldine Holmes
(Date received local registrar) (Registrar's signature)

While at work? no (Specify type of place) _____

(e) Means of injury Trauma

23. Signature James C. Walker (M. Doctor) _____

Address 1924 jpa rd Date signed 12-7-48

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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 Blair E. Weiler

Licensed Embalmer No. 4075

P. O. Address R.O. 8, 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.