DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 35044

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 4019

LEGEND NOV 14 1939

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 (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 25 years years, months or days)

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. 2014 Linker (If rural, give location)

(e) If foreign born, how long in U. S. A.? Life years.

3. (a) PRINT FULL NAME WALTER W FAIRALL

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex M

5. Color or race Wh

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

6. (b) Name of husband or wife Ruth FAIRALL

6. (c) Age of husband or wife if alive 39 years

7. Birth date of deceased Jan (Month) -23- (Day) 1891 (Year)

8. AGE: Years 48 Months 8 Days 24 If less than one day hr. min.

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

10. Usual occupation Salesman

11. Industry or business Cleaning & Dyeing

FATHER
12. Name William W. Fairall
13. Birthplace ✓ (City, town, or county) Ind (State or foreign country)

MOTHER
14. Maiden name Laura Jennett
15. Birthplace Unknown Walker (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Ruth Hall Fairall

(b) Address ✓ 2014 Linker KC Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 20th 39 (Month) (Day) (Year)

(c) Place: burial or cremation Floral Hills

18. (a) Signature of funeral director Roger Henderson

(b) Address 4139 East 15th St

19. (a) 10/20/39 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10-17-39 year hour minute 7:00 a.m.

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

Immediate cause of death Stab wounds of right and left chest

Due to 174

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations ✓
Of autopsy

Duration

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) Homicide

(b) Date of occurrence 10-17-39

(c) Where did injury occur? K.C. (City or town) (County) Mo (State)

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

While at work? (e) Means of injury

23. Signature Trevor W Buhler (M. D. or other)

Address K.C. Mo Date signed

(Licensed Embalmer's Statement on Reverse Side)

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Rev. 5-17-39 1 X19511

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 B. Carp

Licensed Embalmer No. 29555

P. O. Address N.C. 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, above space should be left blank.