

Registration District No. 399 Primary Registration District No. \_\_\_\_\_

JAN 13 1940

1. PLACE OF DEATH: Jackson  
 (a) County Kansas City  
 (b) City or town \_\_\_\_\_  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 3421 Summit 2  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution About 35 Yrs. (Specify whether  
 In this community \_\_\_\_\_ 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. 3421 Summit  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

8. (a) PRINT FULL NAME MARGARET A. BILEY 401  
 8. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Dec day 22  
 year 1939 hour 7 minute 20 P.M.  
 21. I hereby certify that I attended the deceased from Dec 1, 1939, to Dec 22, 1939;  
 that I last saw her alive on Dec 22, 1939;  
 and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Widowed  
 6. (b) Name of husband or wife Fred Biley 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased August 9, 1849  
 (Month) (Day) (Year)

Immediate cause of death Cardiac Decompensation Duration 3 weeks  
 Due to mitral insufficiency 10 yrs  
 Due to Rheumatism years ago.  
 Other conditions 92 W  
 (Include pregnancy within 3 months of death)

8. AGE: Years 90 Months 4 Days 13 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.  
 9. Birthplace Ohio (City, town, or county) (State or foreign country)  
 10. Usual occupation At Home

PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically  
 Major findings: Of operations none  
 Of autopsy none

MOTHER FATHER  
 12. Name Alec Fossitt  
 13. Birthplace Illinois (City, town, or county) (State or foreign country)  
 14. Maiden name Mary O'Connor  
 15. Birthplace Illinois (City, town, or county) (State or foreign country)

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 \_\_\_\_\_  
 28. Signature E. B. Burkhardt (M. D. or other) M.D.  
 Address 3348 Summit Date signed 12/23/39

16. (a) Informant's own signature Mrs. W. E. Shaw  
 (b) Address 3421 Summit  
 17. (a) burial (b) Date thereof 12-26-39  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Mt. Washington  
 18. (a) Signature of funeral director Joseph G. Tabin Co.  
 (b) Address 1111 E. Mo.  
 19. (a) Dec 24, 1939 (b) M. McLean  
 (Date received local registrar) (Registrar's signature)

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.

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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 Maurice M. Quirk

Licensed Embalmer No. 2226

P. O. Address R. C. Ho

**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.**