

FILED JUN 7 1943

Registration District No. 145

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(c) Name of hospital or institution:
2701 E. 35th Street
(d) Length of stay: In hospital or institution _____
In this community 40 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(d) Street No. 2701 E. 35th St 8
(e) Citizen of foreign country? no (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME Samuel Albert Fairies

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Male 0 5. Color or race white
6. (a) Single, widowed, married, divorced, married
6. (b) Name of husband or wife Ora Cecil Fairies
6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased Sept. 6, 1867

8. AGE: Years 75 Months 8 Days 9 If less than one day hr. min.

9. Birthplace Greenfield Missouri

10. Usual occupation Genl. Mgt. Fed. Life & Casualty Co.

11. Industry or business Insurance

MOTHER FATHER { 12. Name Oliver Perry Fairies
13. Birthplace Unknown 9
14. Maiden name Beatha Jane M. Remore
15. Birthplace Unknown 9

16. (a) Informant Ora Cecil Fairies
(b) Address 2701 E. 35th Kansas City, Mo.
17. (a) Removal & burial (b) Date thereof May 17, 1943
(c) Place: burial or cremation Sunset Hill Cemetery, Fairview, Mo.
18. (a) Signature of funeral director C. Clark Beget
(b) Address Raytown, Mo.
19. (a) May 16, 1943 M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 15 year 1943 hour 11 minute 15 A.M.
21. I hereby certify that I attended the deceased from Jan 2, 1943 to May 15, 1943 that I last saw him alive on May 8, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Decomposed by gangrene
Due to Arterio-sclerosis
Due to Chv. Intermittent Exopneustis
Other conditions no 13/10/43
(Include pregnancy within 3 months of death)

Major findings: Of operations none
Of autopsy none
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) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(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 H. D. Wrensch 30
Address 7603 E 31 Date signed 5/15/43

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

Clark Regent

Licensed Embalmer No.

3983

P. O. Address

Raytown 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.