

No. 2  
5-43  
5-17-39  
X36671

FILED NOV 29 1947

State File No. \_\_\_\_\_

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4882

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

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:  
3424 Central St.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution XX (Specify whether)

In this community 56 years (Specify whether 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. 3424 Central  
(If rural, give location)

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

3. (a) PRINT FULL NAME MRS. AGNES FALLON

3. (b) If veteran, name war XX no.

3. (c) Social Security No. None

4. Sex Fe 5. Color or race Wh

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

6. (b) Name of husband or wife John Charles Fallon

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

7. Birth date of deceased April 27 1871  
(Month) (Day) (Year)

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

<u>76</u>	<u>6</u>	<u>22</u>	hr. min.
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9. Birthplace Germany  
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

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

MOTHER FATHER

12. Name John Gabert

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

14. Maiden name No Record

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

16. (a) Informant Henry A. Fallon

(b) Address 5341 Forest

17. (a) Burial (b) Date thereof 11-22-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. St. Mary's Cemetery

18. (a) Signature of funeral director J. Wagner

(b) Address Kansas City, Mo.

19. (a) 11-21-47 (b) Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 19  
year 1947 hour 6: minute 30 P. M.

21. I hereby certify that I attended the deceased from 11-1-47, 19\_\_\_\_ to 11-19-47, 19\_\_\_\_  
that I last saw her alive on 11-15-47, 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death: Generalized cerebral arteriosclerosis

Due to 2

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: 97

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

Of autopsy \_\_\_\_\_

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 0

23. Signature Graham Owens (M. D. or other) \_\_\_\_\_

Address 906 Grand Date signed 11-21-47

Duration ?

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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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..... *Cecil R. Matthes* .....

Licensed Embalmer No. *3807* .....

P. O. Address. *Kansas City, 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.**