

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8489**
Registrar's No. **1106**

BIRTH NO. **FILED MAR 31 1954** REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002**

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Kansas b. COUNTY Cherokee	
b. CITY (If outside corporate limits, write RURAL and give township) Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) WILLIAMS WEIR	
c. LENGTH OF STAY (In this place) 5 years		d. STREET ADDRESS (If rural, give location) 815 8	
d. FULL NAME OF HOSPITAL OR INSTITUTION Little Sisters of the Poor			

3. NAME OF DECEASED (Type or Print) a. (First) Miss Mary	b. (Middle)	c. (Last) Barrett	4. DATE OF DEATH (Month) (Day) (Year) March 10, 1954
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Oct. 1871	9. AGE (In years) (Months) (Days) (Hours) (Min.) 82 years 9 months
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Illinois	12. CITIZEN OF WHAT COUNTRY? U. S.
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13a. FATHER'S NAME Thos. M. Barrett	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mrs Margaret R. Owings ADDRESS 2300 W. 96th
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) Cerebral Hemorrhage	MEDICAL CERTIFICATION Leawood, Kas.		INTERVAL BETWEEN ONSET AND DEATH 1 hr.
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	DUE TO (b) Arteriosclerosis		10 yrs.
ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. Morbid conditions, if any, giving rise to the above cause, (a) stating the underlying cause last.	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **3/9/54**, 19**54**, to **3/10**, 19**54**, that I last saw the deceased live on **3/9/54**, 19**54**, and that death occurred at **7:30 P.M.** from the causes and on the date stated above.

23a. SIGNATURE Joseph A. Fogarty (Degree or title)	23b. ADDRESS 402 Northman Bldg. No. 3110	23c. DATE SIGNED 3/11/54
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24a. BURIAL, CREMATION, OR DISPOSAL (Specify) Burial	24b. DATE March 12, 1954	24c. NAME OF CEMETERY OR CREMATORY St. Bridget's	24d. LOCATION (City, town, or county) (State) Scammon, Kas.
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DATE REC'D BY LOCAL REG. 3.12.54	REGISTRAR'S SIGNATURE Seraldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE Thos. E. Quirk ADDRESS 4316 Troost Ave.
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WRITE PLAINLY--USING 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

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. 3775

P. O. Address _____

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.