

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

27263

State File No. ....

FILED AUG 27 1954

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 3791

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Jackson</u> b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u> c. LENGTH OF STAY (In this place) <u>20 years</u> d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Little Sisters of the Poor</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Jackson</u> c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u> d. STREET ADDRESS (If rural, give location) <u>5331 Highland</u>	
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<b>3. NAME OF DECEASED</b> a. (First) <u>Sister Solange Marie</u> (Type or Print)	b. (Middle) <u>Fournon</u> c. (Last) <u>Fournon</u>	<b>4. DATE OF DEATH</b> (Month) <u>August</u> (Day) <u>3</u> (Year) <u>1954</u>
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<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <u>Single</u>	<b>8. DATE OF BIRTH</b> <u>March 30, 1886</u>	<b>9. AGE</b> (In years last birthday) <u>68 years</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 2 HRS. Hours _____ Min. _____	<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Religious</u>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Nursing Sister</u>	<b>11. BIRTHPLACE</b> (City and State or Foreign Country) <u>New Orleans, La.</u>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>
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<b>13a. FATHER'S NAME</b> <u>Constant Fournon</u>	<b>13b. MOTHER'S MAIDEN NAME</b> <u>Catherine Grimm</u>	<b>14. NAME OF HUSBAND OR WIFE</b> _____
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, No or unknown) (If yes, give war or dates of service) <u>No</u>	<b>16. SOCIAL SECURITY NO.</b> <u>None</u>	<b>17. INFORMANT'S SIGNATURE OR NAME</b> <u>Sister Superior, Little Sisters of the</u>	<b>ADDRESS</b> <u>POOR</u>
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<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	<b>MEDICAL CERTIFICATION</b> <b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*</b> (a) <u>Cardio-renal Failure</u> <b>ANTECEDENT CAUSES</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arterio sclerosis</u> DUE TO (c) <u>Paralysis Agetaria</u>	<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 week</u>  <u>5 yrs</u>  <u>5 yrs</u>
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<b>19a. DATE OF OPERATION</b>	<b>19b. MAJOR FINDINGS OF OPERATION</b> <u>44+</u>	<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)	<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b>
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<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)	<b>21e. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>21f. HOW DID INJURY OCCUR?</b>
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**22. I hereby certify that I attended the deceased from 3/19/50 to 8/3, 1954, that I last saw the deceased alive on 8/3, 1954, and that death occurred at 8:30 m., from the causes and on the date stated above.**

<b>23a. SIGNATURE</b> <u>Joseph A. Fogarty</u> (Deputy)	<b>23b. ADDRESS</b> <u>No. 2402 Northman Blvd. K.C. Mo.</u>	<b>23c. DATE SIGNED</b> <u>8/4/54</u>
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<b>24. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>burial</u>	<b>24b. DATE</b> <u>August 5, 1954</u>	<b>24c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Mary's Cemetery</u>	<b>24d. LOCATION</b> (City, town, or county) (State) <u>K. C. Mo.</u>
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<b>DATE REC'D BY LOCAL REG.</b> <u>8-4-54</u>	<b>REGISTRAR'S SIGNATURE</b> <u>Geraldine Smith</u>	<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Thos. E. Quirk</u> <b>ADDRESS</b> <u>4316 Troost Ave.</u>
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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

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....

Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.