

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41788

STATE FILE NUMBER

5453

FILED JAN 14 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		c. CITY OR TOWN <u>Kansas City</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Little Sisters</u>		d. STREET ADDRESS <u>5331 Highland Ave.</u>	
Length of stay in hospital <u>5 years</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Mrs Izetta</u> Middle _____ Last <u>Walsh</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>13</u> Year <u>1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 15, 1887</u>	9. AGE (In years last birthday) <u>69 years</u>	IF UNDER 1 YEAR Month _____ Day _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and state or country) <u>Ohio</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13. FATHER'S NAME <u>No record</u>	14. MOTHER'S MAIDEN NAME <u>No record</u>
---------------------------------------	----------------------------------------------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mother Lawrence, Little Sisters Home</u>
------------------------------------------------------------------------------------------------------------------------	----------------------------------------	--------------------------------------------------------------

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>20 hrs</u> <u>13 1/2</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arterio sclerosis</u>		
DUE TO (c) <u>Hypertension</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
-----------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

20c. TIME OF INJURY Hour _____ a. m. _____ p. m.	20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20e. CITY, TOWN, OR LOCATION	COUNTY _____ STATE _____
-----------------------------------------------------	-------------------------------------------------------------------------------------------	------------------------------	--------------------------

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION	COUNTY _____ STATE _____
--------------------------------------------------------------------------------------------------------	------------------------------	--------------------------

21. I attended the deceased from 6/18/56 to 12/13/56 and last saw her alive on 12/13/56
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Joseph A. Fogarty</u>	22b. ADDRESS <u>5811 Truman Rd. K.C. Mo</u>	22c. DATE SIGNED <u>12/15/56</u>
--------------------------------------------------------------	------------------------------------------------	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal (Mito)</u>	23b. DATE <u>12.17.56</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Kansas City, Kas.</u>
--------------------------------------------------------------------	------------------------------	------------------------------------------------------------------	---------------------------------------------------------------------------

24. FUNERAL DIRECTOR <u>Thos. E. Quirk</u>	ADDRESS <u>4316 Troost K.C. Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>12-17-56</u>	26. REGISTRAR'S SIGNATURE <u>Nevar Minshall</u>
-----------------------------------------------	----------------------------------------	-------------------------------------------------	----------------------------------------------------

(Licensed Embalmer's Statement on Reverse Side)

alth,
elfare
blic
ervice

300
-56

diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Joseph A. Fogarty

MEDICAL CERTIFICATION

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.....
Signature of Student Embalmer

Signed

Licensed Embalmer No.

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.

.....