

Health,
Welfare
Public
Service

300
1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Otto W. Theel

THE DIVISION OF HEALTH AND HOSPITALS
STANDARD CERTIFICATE OF DEATH

35792
STATE FILE NUMBER
4809
Registrar's No.

FILED NOV 5 1957

Registration District No. 149 Primary Registration District No. 1002

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>KANSAS CITY</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>104 EAST 65 TERR.</u>		Length of stay in 1b <u>37 YEARS</u>	d. STREET ADDRESS (If outside, give location) <u>104 EAST 65 TERR.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>LUCY</u> Middle <u>AMANDA</u> Last <u>FALEY</u>			4. DATE OF DEATH Month <u>OCT.</u> Day <u>15</u> Year <u>1957</u>			
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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>NOV. 19, 1873</u>	9. AGE (In years last birthday) <u>83</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME HOUSE WIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>	11. BIRTHPLACE (City and state or country) <u>IVESDALE, ILLINOIS</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13a. FATHER'S NAME <u>PETER RUEGSEGER</u>	13b. MOTHER'S MAIDEN NAME <u>PAULINA SUITER</u>	14. NAME OF HUSBAND <u>FRED R. FALEY</u>
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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) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>Mrs. Gladys W. Hansen</u> Address <u>104 E. 65 TERR. K.C. MO</u>
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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> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>331+</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes Mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)
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20c. TIME OF INJURY Hour a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from <u>Feb. 1957</u> to <u>Oct. 15, 1957</u> and last saw <u>her</u> alive on <u>Oct 15, 1957</u> Death occurred at <u>4:35 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Otto W. Theel M.D.</u>	22b. ADDRESS <u>4301 Main St. KC Mo</u>	22c. DATE SIGNED <u>10-16-57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>OCT. 19, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SUNSET HILL CEM.</u>	23d. LOCATION (City, town, or county) (State) <u>MANHATTAN, KANSAS</u>
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24. FUNERAL DIRECTOR <u>D. W. Newcomer's Sons</u>	ADDRESS <u>3318 Burtway</u>	25. DATE RECD. BY LOCAL REG. <u>10-18-57</u>	26. REGISTRAR'S SIGNATURE <u>neva minshall</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
Signature of Student Embalmer

Signed *Adrian Jay Still*

Licensed Embalmer No. *4882*

P. O. Address *K.C., 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.