

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-005489
STATE FILE NUMBER 744

FILED MAR 3 - 1958

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

300
-57

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 MO</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kansas City MO</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>7308 Washington</u>		Length of stay in lb <u>39 yrs</u>	d. STREET ADDRESS (If outside, give location) <u>7308 Washington</u>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs Katherine A. Fair</u>		4. DATE OF DEATH Month Day Year <u>2-10-1958</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>3-5-1872</u>
9. AGE (In years last birthday) <u>85</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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>Near Galva Illinois</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME <u>William Craig</u>		13b. MOTHER'S MAIDEN NAME <u>Mary</u>	
14. NAME OF HUSBAND OR WIFE <u>Dr Shields Wesley Fair</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 Address <u>Dr. Moines F. West Senator Hotel, K.C., Mo</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 thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arteriosclerosis</u>			<u>years</u>
DUE TO (c) <u>Chronic Myocarditis</u>			<u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4221</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.)
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <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
21. I attended the deceased from <u>June 8 1957</u> to <u>Feb 10-58</u> and last saw her alive on <u>Feb 10th - 58</u> Death occurred at <u>9 AM</u> P. M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>EMC</u>		22b. ADDRESS <u>20. 3915 Main St K.C. Mo</u>	22c. DATE SIGNED <u>2/10/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>2-13-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Belton Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Belton Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>France-Wornall Funeral Home</u>		25. DATE RECD. BY LOCAL REG. <u>2-12-58</u>	26. REGISTRAR'S SIGNATURE <u>neva minshall</u>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

C. M. Fyfe

All diseases in Part I must be causally related.

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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 *Russell N. France*

Licensed Embalmer No. *4255*

P. O. Address *B. C. M.*

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.