

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-013159

FILED MAY 1 1959

Registration District No. 149 Primary Registration District No. 1002

STATE FILE NUMBER 1896
Registrar's No.

300
-57

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) KANSAS CITY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN KANSAS CITY Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 5511 Forest		Length of stay in lb 47 yrs	d. STREET ADDRESS (If outside, give location) 5511 Forest Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last JANE FRANCES BARRY			4. DATE OF DEATH Month Day Year APRIL 15, 1959
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 31, 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (City and state or country) DIXON, ILLINOIS
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME EDWARD F. CAHILL	
13b. MOTHER'S MAIDEN NAME MARY DONNELLY		14. NAME OF HUSBAND OR WIFE FRANK L. BARRY	
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. NO	17. INFORMANT Address FRANK L. BARRY, 5511 FOREST
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Arterial Thrombosis</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Generalized Arteriosclerosis</i> DUE TO (c) <i>Arterial Hypertension 332X</i>			INTERVAL BETWEEN ONSET AND DEATH <i>7 weeks</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Auricular Fibrillation - Chronic Cardiac Decompensation</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <i>May 21, 1950</i> to <i>April 15, 1959</i> and last saw her alive on <i>April 14, 1959</i> Death occurred at <i>3:00 AM</i> m of the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Carl R. Ferris</i> (Degree or title) M.D.		22b. ADDRESS <i>535 Angelle Bldg Kansas City, Missouri</i>	
22c. DATE SIGNED <i>4-15-59</i>		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
23b. DATE 4-17-59		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	
23d. LOCATION (City, town, or country) (State) Kansas City, Mo.		24. FUNERAL DIRECTOR ADDRESS MELODY-McGILLEY-EYLAR F. H. WOODLAND-LINWOOD	
25. DATE RECD. BY LOCAL REG. 4-16-59		26. REGISTRAR'S SIGNATURE <i>Irene Marshall</i>	

MEDICAL CERTIFICATION
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
All diseases in Part I must be causally related.
Carl R. Ferris

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Dr. Jernol
Osgyle Bldg
Vi 2-8227

3:30 PM - 5 PM

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 *John C. Johnson*

Licensed Embalmer No. *5025*
P. O. Address *Indep. 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.