

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-040042

FILED VS NOV 17 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5210 STATE FILE NUMBER

ENDED
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF NEWCOMER'S
 Carl R. Ferris

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u> Length of stay in 1b <u>60yrs.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>RESEARCH HOSP</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u> c. CITY OR TOWN <u>KANSAS CITY</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>824 W 71st STREET</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>											
3. NAME OF DECEASED First Middle Last <u>MARGARET CONWAY FAUST</u>				4. DATE OF DEATH Month Day Year <u>OCT 29. 1959</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>9 10 83</u>		9. AGE (last birthday) <u>76 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR 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>TOLEDO OHIO</u>				11. BIRTHPLACE (City and state or country) <u>TOLEDO OHIO</u>				12. CITIZEN OF WHAT COUNTRY <u>USA</u>			
13a. FATHER'S NAME <u>UNKNOWN CONWAY</u>				13b. MOTHER'S MAIDEN NAME <u>MARY UNKNOWN</u>				14. NAME OF HUSBAND OR WIFE <u>WILLIAM FAUST</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>486-05-6569D</u> <u>UNKNOWN</u>				17. INFORMANT Address <u>MRS. B. E. FRICKE 1014 EAST 42nd ST.</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>Mesenteric Thrombosis</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease/condition given in PART I (a) <u>Arterial Hypertension - Bundle Branch Block</u>										PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
19. WAS AUTOPSY PERFORMED? YES <input checked="" 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. Month, Day, Year		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. attended the deceased from <u>3-23-1957</u> to <u>10-29-59</u> and last saw her alive on <u>10-28-59</u> Death occurred at <u>2:00 A.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE (Degree or title) <u>Carl R. Ferris M.D.</u>						22b. ADDRESS <u>535 Arquette Bldg Kansas City 6 Missouri</u>				22c. DATE SIGNED <u>10-29-59</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>OCT 31, 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FOREST HILL CEM</u>				23d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MO.</u>							
24. FUNERAL DIRECTOR ADDRESS <u>D. W. NEWCOMER'S SONS K. C. MO.</u>						25. DATE RECD. BY LOCAL REG. <u>10-30-59</u>		26. REGISTRAR'S SIGNATURE <u>Walter Marshall</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

Robert L. Fuller

Licensed Embalmer No. 4878

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.