

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-034730

FILED VS OCT 14 1960

149

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

4934

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b "unknown"		c. CITY OR TOWN <b>Kansas City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>General Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>315 West 9th. st.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>HENRY</b> Last <b>FARLEY</b>				4. DATE OF DEATH Month <b>9</b> Day <b>29</b> Year <b>60</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>7-5-93</b>		9. AGE (last birthday) <b>67</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>			
13a. FATHER'S NAME <b>Henry Farley</b>				13b. MOTHER'S MAIDEN NAME <b>Louise "UNKNOWN"</b>				14. NAME OF HUSBAND OR WIFE <b>"UNKNOWN"</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>"unknown"</b>		17. INFORMANT Address <b>Mr. Jasper H. Farley; Alton, Missouri</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b>										INTERVAL BETWEEN ONSET AND DEATH			
DUE TO (b) <b>Fibrillation</b>													
DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)										PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N- <input type="checkbox"/> Unknown			
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 <b>8-17-60</b> to <b>9-29-60</b> and last saw her/him alive on <b>9-29-60</b> Death occurred at <b>11:15 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <b>H. L. Dwyer</b> (Degree or title)						22b. ADDRESS <b>M.D., 2400 Cherry St. - K.C., Mo.</b>			22c. DATE SIGNED <b>9-29-60</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>10-1-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mountn Calvary Cemetery</b>				23d. LOCATION (City, town, or county) (State) <b>Kansas City, Kansas</b>					
24. FUNERAL DIRECTOR ADDRESS <b>Weillert Funeral Homes (S) K.C., Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>10-1-60</b>		26. REGISTRAR'S SIGNATURE <b>H. L. Dwyer</b>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF H. L. Dwyer

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Blaine E. Weel

Licensed Embalmer No. 4078

P. O. Address R. E. 8, 1

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.