

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-012332

STATE FILE NUMBER

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 42

AMENDED

FILED APR 4 1961

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| 1. PLACE OF DEATH a. COUNTY Vernon | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Washington Township | | c. CITY OR TOWN Independence | |
| Length of stay in lb 3 yrs. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Hosp. # 3 | | d. STREET ADDRESS (If outside, give location) 1400 N. River Road | |
| Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) First Blanche Middle Farley Last Farley | 4. DATE OF DEATH Month March Day 28 Year 1961 |
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| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 4-17-1872 | 9. AGE (last birthday) 89 | IF UNDER 1 YEAR Months 0 Days 0 | IF UNDER 24 HR Hours 0 Min. 0 |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | 10b. KIND OF BUSINESS OR INDUSTRY None | 11. BIRTHPLACE (City and state or country) Wisner, Nebraska | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
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| 13a. FATHER'S NAME William Farley | 13b. MOTHER'S MAIDEN NAME Eliza Cole | 14. NAME OF HUSBAND OR WIFE Single |
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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) no | 16. SOCIAL SECURITY NO. Unknown | 17. INFORMANT State Hospital # 3, Nevada, Mo. | Address |
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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: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Coronary Vessel Disease | | Years |
| Conditions, if any, which gave rise to above cause (b), stating the underlying cause last. | DUE TO (b) Atheromatous Sclerosis | Years |
| | DUE TO (c) | |

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| 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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
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| 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 11:55 a.m. Month, Day, Year 11-26-58 | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 11-26-58 to 3-28-61 and last saw her ^{her} _{his} alive on 3-28-61 Death occurred at 11:55 a.m. on the date stated above, and to the best of my knowledge, from the causes stated. | |
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| 22a. SIGNATURE <i>W. E. Bradley M.D.</i> (Degree or title) | 22b. ADDRESS <i>State Hospital # 3 Nevada</i> | 22c. DATE SIGNED 3-28-61 |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Creml</i> | 23b. DATE 3-31-61 | 23c. NAME OF CEMETERY OR CREMATORY <i>Macon Gene</i> | 23d. LOCATION (City, town, or county) <i>Independence Mo.</i> |
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| 24. FUNERAL DIRECTOR <i>Rafael H. Sparks Funeral Home</i> <i>Indep. Mo.</i> | ADDRESS | 25. DATE RECD. BY LOCAL REG. 3-30-1961 | 26. REGISTRAR'S SIGNATURE <i>Anna E. Gerry</i> |
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SHOULD READ

ITEM NO.

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 Roland R. Spohn

Licensed Embalmer No. 3604

P. O. Address Independence

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.