

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-030958

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4469

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 14 1962

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF **Joseph A. Fogarty** MEDICAL CERTIFICATION

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) OR TOWN KANSAS CITY		Length of stay in 1b 11 years	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 LITTLE SISTERS HOME		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5331 HIGHLAND Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First BRIDGET Middle - Last ENIS		4. DATE OF DEATH Month AUGUST Day 29 Year 1962	
5. SEX Female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH July 10, 1871
9. AGE (last birthday) 91 yrs		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (City and state or country) ATHENS, OHIO
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME JOHN FERRITOR	
13b. MOTHER'S MAIDEN NAME JOHANNA KENNEY		14. NAME OF HUSBAND OR WIFE AUGUST ENIS--Deceased	
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. NONE	17. INFORMANT Address Mrs. Robert O'Gorman, 208 E. 31st St.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arterio sclerosis DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 30 yrs.
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"/> No <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 _____ 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. I attended the deceased from <u>3/19/50</u> to <u>8/29/62</u> and last saw her ^{her} alive on <u>8/28/62</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or Title) <i>Joseph A. Fogarty M.D.</i>		22b. ADDRESS <i>402 Witherspoon St. St. Louis, Mo.</i>	22c. DATE SIGNED <i>8/30/62</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-31-1962	23c. NAME OF CEMETERY OR CREMATORY St. Columba Cemetery	23d. LOCATION (City, town, or county) Conception, Missouri
24. FUNERAL DIRECTOR MUEHLEBACH, 6800 Troost Ave. K. C. Mo.		25. DATE RECD. BY LOCAL REG. 8-30-62	26. REGISTRAR'S SIGNATURE <i>Ruth Long</i>

USE BLACK INK OR TYPEWRITER RIBBON

Dr. Fogarty
Lakeside Hospital
29th & Flora

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 _____

Licensed Embalmer No. 4421

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.