

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

28076  
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson / Registration District No. 399  
(b) Township Jean / Primary Registration District No. 100  
(c) City Kansas City (d) Street No. 7 C Gen Hosp St.  
(If death occurred in hospital or institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. 0 How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Clement A. Farrell (Clement A. Farrell)  
(a) Residence, No. 3001 Main St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 9 1909  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 30 5 22

OCCUPATION  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Clinical  
9. Industry or business in which work was done, as saw mill, bank, etc. work  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Salt Lake City Utah

FATHER  
13. NAME William Farrell  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas

MOTHER  
15. MAIDEN NAME Cecilia Reardon  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas

17. INFORMANT (ADDRESS) Reena Clark 7 C Gen Hosp

18. BURIAL, CREMATION, OR REMOVAL PLACE Salvage Bldg DATE 9/3/39 19.

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. J. Magberry, K C Hosp

20. FILED 9/2 19 39 M. M. Grove Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-1 19 39

22. I HEREBY CERTIFY, That I attended deceased from 7-30 19 39 to 8-1 19 39  
I last saw him alive on 8-1 19 39 Death is said to have occurred on the date stated above, at 6:40 P.M.  
The principal cause of death and related causes of importance were as follows:

Osteomyelitis of left tibia and of 7th dorsal vertebrae (Non tuberculous)  
Other contributory causes of importance: Staphylococcus Septicemia

Name of operation \_\_\_\_\_ Date of: \_\_\_\_\_  
What test confirmed diagnosis? 15 Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_ 19 \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_  
(Signed) R. J. De Maria M. D.  
(Address) Supr 7 C Gen Hosp

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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 .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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 this body is not embalmed, above space should be left blank.**