

No. 2
12-45
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X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36948

FILED NOV 20 1946

State File No. _____

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 5210

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1329 Linwood Boulevard
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution... none (Specify whether
In this community... 7 years (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No. 1329 Linwood Boulevard 8
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 8
year 1946 hour 11 minute 20 A.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death coronary sclerosis
Due to arteriosclerosis

Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: _____

Of operations _____
Of autopsy History + Inspection

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

23. Signature J. M. [unclear] (M. D. or other) 3
While at work? _____ (Specify type of place) (e) Means of injury _____
Address 1824 [unclear] Date signed 11-9-46

3. (a) PRINT FULL NAME Omar K. FAIRES
3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased February 28, 1879
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
67 8 10 hr. min.

9. Birthplace St. Jacob, Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Veterinarian

11. Industry or business Own

12. Name John Faires

13. Birthplace Illinois
(City, town, or county) (State or foreign country)

14. Maiden name Ellen Adams

15. Birthplace Lebanon, Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Dr. John Faires

(b) Address St. Jacob, Illinois

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 11-9-46
(Month) (Day) (Year)

(c) Place: burial or cremation St. Jacob, Illinois

18. (a) Signature of funeral director Melody-McGilley-Ev ar

(b) Address Kansas City, Missouri

19. (a) 11-9-46 (Date received local registrar) (b) Geraldine Helms (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

35700

Duration

PHYSICIAN

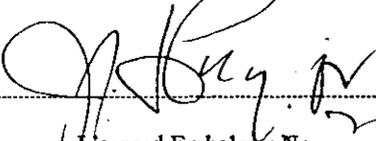
Underline the cause to which death should be charged statistically.

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. 2599

P. O. Address..... K C

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, fact should be so stated above.