

No. 2  
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-17-39  
X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED JUN 9 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 17399  
Registrar's No. 2348

Registration District No. 149 Primary Registration District No. 1002

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Kansas City  
(c) Name of hospital or institution St. Joseph Hospital  
(d) Length of stay: In hospital or institution 6 weeks  
In this community life

3. (a) PRINT FULL NAME Baby Paul Francis Farley  
3. (b) If veteran, name war no. 3. (c) Social Security No. no.

4. Sex male 5. Color or race white  
6. (a) Single, widowed, married, divorced infant  
6. (b) Name of husband or wife X 6. (c) Age of husband or wife if alive X years  
7. Birth date of deceased March 31 1947

8. AGE: Years Months Days If less than one day  
- 21 26 hr. min.

9. Birthplace Kansas (City, town, or county) (State or foreign country)

10. Usual occupation infant

11. Industry or business X

12. Name Dr. Claude C. Farley

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

14. Maiden name Dorothy Hart

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

16. (a) Informant Dr. Claude C. Farley

(b) Address 4310 W. 69th Ter., Kansas City, Mo

17. (a) burial (b) Date thereof 5-28-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt MORIAH, CEM.

18. (a) Signature of funeral director Stine & McClure

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 5-29-47 (Date received local registrar) (b) Heraldine Holmes (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Kansas (b) County Johnson  
(c) City or town Mission City  
(d) Street No. 4310 West 69th Terrace  
(e) Citizen of foreign country? no.  
If yes, name country X

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 27 year 1947 hour 8 minute P. M.

21. I hereby certify that I attended the deceased from 19... to 19... that I last saw... and that death occurred on the date and hour stated above.

Immediate cause of death: Internal Hydrocephalus Severe

Due to: Congenital Malformation of Brain & Spinal Cord

Other conditions: (Include pregnancy within 3 months of death) 157 d

Major findings: Of operations Tracheotomy

Of autopsy: above

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?  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work (Specify type of place) (c) Means of injury

23. Signature of Physician: Russell Jensen Date signed 28 May 47

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

MOTHER FATHER

**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 Robert H. Reed  
Licensed Embalmer No. 3745  
P. O. Address KC. 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 this body is not embalmed, fact should be so stated above.**