

No. 300
M-10-47
v. 5-17-39
I 3906

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED SEP 13 1948

MISSOURI DEPARTMENT OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29747
Registrar's No. 3584

Registration District No. 149

Primary Registration District No. 1002

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

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:
402 Bellefontaine
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution XX (Specify whether
In this community 65 years
years, months or days)

3. (a) PRINT FULL NAME MRS. ELENORA FARGARSTON
3. (b) If veteran, name war XX 3. (c) Social Security No. None

4. Sex Fe 5. Color or race Wh
6. (a) Single, widowed, married, divorced 2 Widowed
6. (b) Name of husband or wife Peter S. Fargarston
6. (c) Age of husband or wife if alive XX years
7. Birth date of deceased. May 21 1866
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
82 3 10 hr. min.

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

10. Usual occupation At Home

11. Industry or business

MOTHER FATHER { 12. Name Obe Chumley
13. Birthplace No Record
(City, town, or county) (State or foreign country)

14. Maiden name " " 15. Birthplace " "
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Virginia Naylor

(b) Address 402 Bellefontaine

17. (a) Burial (b) Date thereof 9-3-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director J.W. Wagner
(b) Address Kansas City, Mo.

19. (a) 9-2-48 (b) Heraldine Holmer
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 402 Bellefontaine
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept. day 1
year 1948 hour 1: minute 40 A. M.

21. I hereby certify that I attended the deceased from Jan
2, 1948, to Sept 1, 1948
that I last saw her alive on day 31/1948
and that death occurred on the date and in the place stated above.

Immediate cause of death Chronic Interstitial Nephritis + Myocarditis
Due to Infection in placenta body 2 years
Due to _____

Other conditions Chronic Interstitial Nephritis
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy 131a

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? 0

While at work _____ (Specify type of place) (e) Means of injury _____
23. Signature Fanny W. Dwyer (M. D. or other) _____
Address 1401 Prospect Ave Date signed 9-2-48

1401
C H 8347
W. F. W. A. H. H.

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 Alvin R. Hainscheld

Licensed Embalmer No. 4159

P. O. Address Kansas City 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.