

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24437

State File No. 3373

FILED AUG 4 1952

BIRTH NO. REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No.

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, write RURAL and give township) OR TOWN Kansas City		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City	
c. LENGTH OF STAY (In this place) 50 yrs		d. STREET ADDRESS (If rural, give location) 2802 Independence Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Simpson Nursing Home			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) HELEN	b. (Middle) A.	c. (Last) FARNSWORTH	7	26	52
5. SEX Fe	6. COLOR OR RACE Wh	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Never Married	8. DATE OF BIRTH 9-1-1874		9. AGE (In years last birthday) 77
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing (Prof)	11. BIRTHPLACE (State or foreign country) Pontiac, Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Berton F. Farnsworth	13b. MOTHER'S MAIDEN NAME Augusta Bartlett	14. NAME OF HUSBAND OR WIFE XX
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) XX	17. INFORMANT'S SIGNATURE OR NAME A.E. Farnsworth, 4020 N. Grand KC North	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 5 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		331X	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR
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22. I hereby certify that I attended the deceased from 7/21, 1952, to 7/26, 1952, that I last saw the deceased alive on _____, 19____, and that death occurred at 10:00 A.M., from the causes and on the date stated above.

23a. SIGNATURE Paul Lowell (Degree or title) Paul Lowell M.D.	23b. ADDRESS 6105 Swape Pkwy	23c. DATE SIGNED 7/26/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7-28-52	24c. NAME OF CEMETERY OR CREMATORY Forest Hill	24d. LOCATION (City, town, or county) (State) Kansas City Mo.
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DATE REC'D BY LOCAL REG. 7-28-52	REGISTRAR'S SIGNATURE Geraldine Holmes	25. FUNERAL DIRECTOR'S SIGNATURE J. M. Wagner	ADDRESS K C Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

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6105
K.E. 8323
Kerridge 1934

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed Alvin R. Haunschild

Signed.....
Student Embalmer

Licensed Embalmer No. 4159

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 this body is not embalmed, fact should be so stated above.