

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

246

State File No. ....

FILED FEB 1 1954

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 80

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Joseph</b>		c. CITY OR TOWN <b>St. Joseph</b>	
c. LENGTH OF STAY (in this place) <b>25 Yrs</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Wyatt Park Nursing Home</b>		e. STREET ADDRESS (If rural, give location) <b>2715 Lafayette St.</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Ella</b> b. (Middle) c. (Last) <b>Fogarty.</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Jan. 22, 1954.</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never Married</b>	8. DATE OF BIRTH <b>? ? 1872</b>	9. AGE (In years last birthday) <b>81</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>at Home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Illinois</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Michael Fogarty</b>	13b. MOTHER'S MAIDEN NAME <b>Anne Byrne</b>	14. NAME OF HUSBAND OR WIFE <b>None</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs Agnes Mayse</b>	ADDRESS <b>2715 Lafayette City</b>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>4-5 yrs</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cardiac Failure</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis Gen</b> DUE TO (c) <b>Myocardial insufficiency</b>		<b>Years</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Gen. Sensitivity</b>			<b>Years</b>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>4/22/54</b>	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 **1948**, to **Jan 22, 1954**, that I last saw the deceased alive on **1-9, 1954**, and that death occurred at **11:15 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>R. Kiehl M.D.</b>	(Degree or title)	23b. ADDRESS <b>Kirkpatrick Bldg - St Joseph Mo</b>	23c. DATE SIGNED <b>1-25-54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>1-25-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>	24d. LOCATION (City, town, or county) (State) <b>St. Joseph, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>Jan 26, 1954</b>	REGISTRAR'S SIGNATURE <b>Katherine M. Allison</b>	495	25. FUNERAL DIRECTOR'S SIGNATURE <b>Herman W. Bedenfadner</b>	ADDRESS <b>1802 Union St</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

**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 ..... Student Embalmer No.....

working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Robert H. Geph*.....

Licensed Embalmer No. 3308

P. O. Address St. Joseph, .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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