

FILED MAY 17 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15791**
1869

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 Buchanan | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City | | c. CITY OR TOWN St. Joseph | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. LENGTH OF STAY (in this place) 2 Yrs. | | e. STREET ADDRESS (If rural, give location) 2717 Lafayette | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Little Sisters of the Poor | | | |

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|---|--|---|--|--|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) Frances b. (Middle) A. c. (Last) CAREY | | | 4. DATE OF DEATH (Month) (Day) (Year) April 25, 1954 | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married 0 | |
| 8. DATE OF BIRTH 2-5-69 | | 9. AGE (In years last birthday) 85 | | 10. IF UNDER 1 YEAR Months _____ Days _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Invalided | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | 11. BIRTHPLACE (City and State or Foreign Country) St. Joseph, Missouri 0 | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | |

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|--|--|---|--|--|--|
| 13a. FATHER'S NAME John H. Carey | | 13b. MOTHER'S MAIDEN NAME Nancy W. Gilmore | | 14. NAME OF HUSBAND OR WIFE none | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS J. S. Gilmore, St. Joseph, Missouri | |

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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. | | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broncho pneumonia, Hypostatic | | INTERVAL BETWEEN ONSET AND DEATH 3 days | |
| | | 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. Coronary of Pectum 15/18 | | 6 mos | |
| 19a. DATE OF OPERATION _____ | | 19b. MAJOR FINDINGS OF OPERATION _____ | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |

| | | | | | |
|---|--|--|--|---|--|
| 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) _____ | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? _____ | |

22. I hereby certify that I attended the deceased from **9/19**, 19**52**, to **4/25**, 19**54**, that I last saw the deceased alive on **4/24**, 19**54**, and that death occurred at _____ m., from the causes and on the date stated above.

| | | | | | |
|--|--|---|--|---|--|
| 23a. SIGNATURE Joseph A. Fogarty (Ink or title) | | 23b. ADDRESS 402 Withman Bldg 6316 | | 23c. DATE SIGNED 4/26/54 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 24b. DATE 4-26-54 | | 24c. NAME OF CEMETERY OR CREMATORY _____ | |
| | | | | 24d. LOCATION (City, town, or county) (State) St. Joseph, Missouri | |

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|---|--|---|--|---|--|
| DATE REC'D BY LOCAL REG. 4-26-54 | | REGISTRAR'S SIGNATURE Sheldine Smith | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Melody-McGilley-Eylar, Kansas City, Mo. | |
|---|--|---|--|---|--|

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

Dr. J. A. Fogarty

Wirthman Bldg.

after 12:30

201207

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 *Arthur Eugene Naak*.....

Licensed Embalmer No. *491*

P. O. Address *K.P. 71*.....

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.