

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **27245**  
**3568**

FILED AUG 18 1954

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

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>KANSAS CITY</b>		c. CITY OR TOWN <b>KANSAS CITY</b>	
c. LENGTH OF STAY (In this place) <b>4 mo.</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>WESTPORT REST HOME MOBILE</b>		e. STREET ADDRESS (If rural, give location) <b>PENSMORE HOTEL 3128</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Ethel</b> b. (Middle) <b>S.</b> c. (Last) <b>FARLEY</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>July 20, 1954</b>		
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5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED, <input checked="" type="checkbox"/> WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH <b>OCT. 11, 1872</b>		9. AGE (In years last birthday) <b>72</b>		10. IF UNDER 1 YEAR Months _____ Days _____		11. IF UNDER 4 HRS. Hours _____ Min. _____	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HEAD OF SWEATER DEPT.</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>CLOTHING STORE</b>			11. BIRTHPLACE (City and State or Foreign Country) <b>VIRGINIA!</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
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13a. FATHER'S NAME <b>S. A. FARLEY</b>			13b. MOTHER'S MAIDEN NAME <b>NANNIE SMITH</b>			14. NAME OF HUSBAND OR WIFE _____		
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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>500-22-0427</b>		17. INFORMANT'S SIGNATURE OR NAME <b>MRS. FLOYD WINSLOW, MORAN</b>		ADDRESS <b>KANSAS</b>	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <b>24 hours.</b>	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Hemorrhage</b>				<b>331X</b>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.					
		DUE TO (b) <b>Senility - Arteriosclerosis.</b> DUE TO (c) _____					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							

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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>Natural Causes.</b>	
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22. I hereby certify that I attended the deceased from **20 July, 1954**, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on **20 July, 1954**, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23a. SIGNATURE <b>Wallace H. Graham M.D.</b> (Degree or title)		23b. ADDRESS <b>518 Argyle Bldg. K.C., Mo.</b>		23c. DATE SIGNED <b>21 July '54.</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>July 23, 1954</b>		24c. NAME OF CEMETERY OR CREMATORY <b>MORAN CEMETERY</b>		24d. LOCATION (City, town, or county) (State) <b>MAJOR AVE KANSAS</b>	
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DATE REC'D BY LOCAL REG. <b>7-22-54</b>		REGISTRAR'S SIGNATURE <b>Heraldine Smith</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>D. W. NEWCOMER'S SON'S</b>		ADDRESS <b>K.C. Mo.</b>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD  
Wallace H. Graham MD

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 *Clare V. Camp* .....

Licensed Embalmer No. *4934*

P. O. Address *R. C. 10, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.