

FILED AUG 27 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27250

3809

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. LENGTH OF STAY (in this place) 35 yrs.		c. CITY OR TOWN Kansas City		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 623 Euclid, Conv. Home				f. STREET ADDRESS (If rural, give location) 5531 Bales					
3. NAME OF DECEASED (Type or Print) a. (First) GEORGE		b. (Middle) G.		c. (Last) FERRIS		4. DATE OF DEATH (Month) (Day) (Year) Aug. 5 1954			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Aug. 7, 1886		9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (City and State or Foreign Country) Illinois		12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME Henry Ferriss		13b. MOTHER'S MAIDEN NAME Marguerite McCarthy		14. NAME OF HUSBAND OR WIFE Irene Ferris					
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. 709-12-unknown 7380		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. J.T. Henry, 5531 Bales, K.C., Mo.					
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 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Interstitial Nephritis				INTERVAL BETWEEN ONSET AND DEATH	
				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
				11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Alcoholism				5927	
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 7/27 , 19 53 , to 7/30 , 19 54 , that I last saw the deceased alive on 7/20 , 19 54 and that death occurred at 4:30 Am. , from the causes and on the date stated above.									
23a. SIGNATURE R.A. Williams (Degree or title) D				23b. ADDRESS 143 MD - 6400 St. Johns as City, Mo		23c. DATE SIGNED 8/5/54			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 8-5-54		24c. NAME OF CEMETERY OR CREMATORY —		24d. LOCATION (City, town, or county) (State) Chillicothe, Missouri			
DATE REC'D BY LOCAL REG. 8-5-54		REGISTRAR'S SIGNATURE Sealdine Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS STINE & McCLURE UND. CO.		K.C.MO.			

(Licensed Embalmer's Statement on Reverse Side)

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

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p. 300
p. 48

Dr. Frank Williams
5400 St. James
Dec. 26 59

Exp. - 4:30 PM

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 *J. T. Crowell*

Licensed Embalmer No. *490*

P. O. Address *H. C. 2*

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.