

FILED OCT 20 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4604**

34189

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Jackson</u>					
b. CITY (If outside corporate limits, write RURAL and give township) <u>W. Kansas City</u>		c. LENGTH OF STAY (in this place) <u>6 yrs</u>		c. CITY OR TOWN <u>Kansas City</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> <u>4</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Little Sisters of the Poor</u>				e. STREET ADDRESS (If rural, give location) <u>5331 Highland</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Elizabeth</u>			b. (Middle) _____		c. (Last) <u>Timmons</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 26th 1954</u>		
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>		8. DATE OF BIRTH <u>July 16 1875</u>		9. AGE (In years last birthday) <u>79 years</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>1</u>		
13a. FATHER'S NAME <u>Michael Timmons</u>			13b. MOTHER'S MAIDEN NAME <u>Honora Sheehan</u>			14. NAME OF HUSBAND OR WIFE <u>Single</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Little Sisters of the Poor K.C. Mo.</u>				ADDRESS	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSES <u>Hypertension</u> <u>Atherosclerosis</u> DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 mos.</u> <u>6 yrs.</u> <u>1 yr.</u>	
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? <u>331X</u>					
22. I hereby certify that I attended the deceased from <u>2/19</u> , 19 <u>50</u> , to <u>9/26</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>9/26</u> , 19 <u>54</u> , and that death occurred at _____ m., from the causes and on the date stated above.									
23a. SIGNATURE <u>Joseph A. Fogarty</u>				23b. ADDRESS <u>402 Northman Sq. K.C. Mo.</u>		23c. DATE SIGNED <u>9/29/54</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Sept. 30, 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		24d. LOCATION (City, town, or county) (State) <u>K.C. Mo.</u>			
DATE REC'D BY LOCAL REG. <u>10-1-54</u>		REGISTRAR'S SIGNATURE <u>Neve Marshall</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas E. Quirk</u>				ADDRESS <u>4316 Troost Ave.</u>	

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD
Joseph A. Fogarty

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 *Thomas E. Zuehl*.....

Licensed Embalmer No. *372*.....

P. O. Address.....

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.