

FILED MAY 7 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

131809
STATE FILE NUMBER
1939

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1939

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>KANSAS</u> b. COUNTY <u>JOHNSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>SHAWNEE</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. MARY'S HOSPITAL</u>		Length of stay in lb <u>6 Days</u>	d. STREET (If outside, give location) ADDRESS <u>815 11101 WEST 57th TERR.</u> Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>LORENA</u> Middle <u>B.</u> Last <u>FALER</u>			4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1957</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT-14, 1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>75</u> F UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (City and state or country) <u>Near Elk City, Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Charles Dancer</u>		13b. MOTHER'S MAIDEN NAME <u>Harriette Miller</u>	14. NAME OF HUSBAND OR WIFE <u>C. D. Faler</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>MRS. HUBERT WAUGH</u> Address <u>1040 SOUTH 55th ST. K.C., KANSAS</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular hemorrhage.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>General arteriosclerosis.</u> <u>Complicated by Managed auricular fibrillation</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>331+</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>4 yrs</u> <u>1 month ±</u>
20a. ACCIDENT SUICIDE HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>0</u>	
20c. TIME OF INJURY Hour : Month, Day, Year a.m. p.m. <u>0</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>0</u>		20f. CITY, TOWN, OR LOCATION. <u>0</u>	COUNTY <u>0</u> STATE <u>0</u>
21. I attended the deceased <u>Continued to hospital 4/13/57</u> to <u>4/19/57</u> and last saw her alive on <u>4-19-57</u> . Death occurred at <u>6:05 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>A. Myers</u> <u>[Signature]</u> (Degree or title) <u>0</u>		22b. ADDRESS <u>1115 Grand Ave. K.C. Mo.</u>	22c. DATE SIGNED <u>4/20/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>April 24, 1957</u>	23c. NAME OF CEMETERY OR REPOSITORY <u>Mt. Moriah Cemetery</u>
23d. LOCATION (City, town, or county) <u>Kansas City</u>		23e. STATE <u>Missouri</u>	
24. FUNERAL DIRECTOR <u>D. W. NEWCOMER'S Sons</u> ADDRESS <u>1331 Brush Creek K.C. Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>4-24-57</u>	26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u>

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

300
1-57



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 *Raymond M Hardy*

Licensed Embalmer No. *4913*

P. O. Address *Indef. 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.