

# DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-029070

FILED VS SEP 1 1959

149

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3976 STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Jackson</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Barton Rest Home</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Kansas</u> b. COUNTY <u>Johnson</u> c. CITY OR TOWN <u>Fairway</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>5520 Fairway</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Length of stay, in 1b <u>4 months 25 yrs</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Mary Jope Farmer</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>Aug 16 - 1959</u>				
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Oct 28 1875</u>	<b>9. AGE (last birthday)</b> <u>83</u>	IF UNDER 1 YEAR Months Days Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>at home</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Wilkes Barre Penn</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>	
<b>13a. FATHER'S NAME</b> <u>Wm Peard</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Agnes Carrio Wallace</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Harlan G Farmer</u>		Address <u>5520 Fairway</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> —		<b>17. INFORMANT</b> <u>Mrs. Helen Izard</u>		Address <u>5520 Fairway</u> <u>W.C. Kans.</u>	

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic Heart Disease 10 yrs</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Fract of Rt hip 2 mo</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input checked="" type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE	
<b>21. I attended the deceased from</b> <u>Jan 58</u> to <u>Death</u> and last saw her alive on <u>July 21 1959</u> Death occurred at <u>August 16 5a</u> on the date stated above, and to the best of my knowledge, from the causes stated.		<b>22a. SIGNATURE</b> (Degree or title) <u>J.P. Macer M.D.</u>		<b>22b. ADDRESS</b> <u>Mission Kans</u>		<b>22c. DATE SIGNED</b> <u>8/18/59</u>		
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE</b> <u>Aug 18 - 1959</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Moriah Cemetery</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>Kansas City Mo.</u>		
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>C.H. Blackburn &amp; Son Inc Kansas City Mo</u>		<b>25. DATE RECD. BY LOCAL REG</b> <u>8-17-59</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Neva Minshall</u>				

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to 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.