

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-032328

FILED OCT 13 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4693

STATE FILE NUMBER

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, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in lb <b>35 Yrs</b>	c. CITY OR TOWN <b>Kansas City</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>1602 E. 73rd</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>1602 E. 73rd.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>A</b> Last <b>FAIRCHILD</b>	4. DATE OF DEATH Month <b>9</b> Day <b>27</b> Year <b>1959</b>
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5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8 29 62</b>	9. AGE (last birthday) <b>97</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Carpenter</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Carpenter</b>	11. BIRTHPLACE (City and state or country) <b>Harrisburg, Penn</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S. A</b>
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13a. FATHER'S NAME <b>Mason Fairchild</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Agnes Fairchild</b>
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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>NONE</b>	17. INFORMANT Address <b>Mrs. Ethel Jines 1602 E. 73rd.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Age -</b>	
	DUE TO (c) <b>Arteriosclerosis</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour <b>11</b> a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>Kansas City Missouri</b>
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21. I attended the deceased from <b>1950</b> <b>7-27-1959</b> and last saw him alive on <b>9-23-59</b> Death occurred at <b>11 pm 9-27-59</b> m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>George V. Feist MD</b> (Degree or title)	22b. ADDRESS <b>702 Professional B</b>	22c. DATE SIGNED <b>9-28-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10-1-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Floral Hills</b>	23d. LOCATION (City, town, or county) (State) <b>Kansas City Missouri</b>
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24. FUNERAL DIRECTOR <b>Floral Hills Mem. Ghapels, Inc</b>	ADDRESS <b>K. C. Mo</b>	25. DATE RECD. BY LOCAL REG. <b>9-28-59</b>	26. REGISTRAR'S SIGNATURE <b>neva minshall</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

George V. Feist

**STATEMENT BY LICENSED EMBALMER**

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

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

Signed Forrest D. Goldano

Licensed Embalmer No. # 4714

P. O. Address F. C. Mo

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