

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-036161

FILED VS NOV 2 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5012 STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Kansas</b> b. COUNTY <b>Johnson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in 1b <b>1 day</b>	c. CITY OR TOWN <b>Shawnee</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>St Mary's Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5612 Nieman Rd</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>WAUNITA</b> Middle <b>FAILES</b> Last <b>FAILES</b>			4. DATE OF DEATH Month <b>Oct</b> Day <b>17</b> Year <b>1959</b>			
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5. SEX <b>Fe</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4-24-1922</b>	9. AGE (last birthday) <b>37 yrs</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>	11. BIRTHPLACE (City and state or country) <b>Lincoln, Neb.</b>	12. CITIZEN OF WHAT COUNTRY <b>U S A</b>
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13a. FATHER'S NAME <b>Donald E Stout</b>	13b. MOTHER'S MAIDEN NAME <b>Martha I McPeeters</b>	14. NAME OF HUSBAND OR WIFE <b>Francis Failes</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>509 16 1023</b>	17. INFORMANT <b>Francis Failes</b> Address <b>Shawnee, Kansas</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>Subarachnoid Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
DUE TO (b) <b>Previous Subarachnoid Hemorrhage</b>		
DUE TO (c) _____		<b>3 wks.</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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ a.m. _____ p.m. Month, Day, Year _____
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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>Shawnee, Kansas</b>	COUNTY <b>Johnson</b>	STATE <b>Kansas</b>
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21. I attended the deceased from <b>9-24-59</b> to <b>10-17-59</b> and last saw <sup>her</sup> <b>306</b> alive on <b>10-17-59</b> Death occurred at <b>8:05 pm</b> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>Paul B. Burger, M.D.</b>	22b. ADDRESS <b>5949 Nieman - Shawnee, Ko.</b>	22c. DATE SIGNED <b>10/19/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Oct 21, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Johnson Co. Mem. Gardens</b>	23d. LOCATION (City, town, or county) (State) <b>Johnson County, Kansas</b>
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24. FUNERAL DIRECTOR <b>F A Reising</b> ADDRESS <b>K C Ks</b>	25. DATE RECD. BY LOCAL REG. <b>10-19-59</b>	26. REGISTRAR'S SIGNATURE <b>Irlva Marshall</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF Paul B. Burger

**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 \_\_\_\_\_

*George A. Reisinger*

Licensed Embalmer No. 4468

P. O. Address K C Ks

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.