

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-001570

365 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

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

FILED FEB 8 1963

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Rev. 4/59

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DATE AMENDED

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INSTEAD OF

ITEM NO. SHOULD READ

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

W. Riller

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Jackson | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | | Length of stay in 1b 1 yr. | c. CITY OR TOWN Pleasant Hill, Mo. |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Kelly Nursing Home | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First CHARLES Middle FORAN Last FORAN | | 4. DATE OF DEATH Month 1 Day 17 Year 1963 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 9-27-1874 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (last birthday) 89 88 |
| 11. BIRTHPLACE (City and state or country) Illinois | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME James Foran | | 13b. MOTHER'S MAIDEN NAME Martha Gilly | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of war) Yes WWI | | 14. SOCIAL SECURITY NO. _____ | |
| 18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage | | 17. INFORMANT V A Hospital, Kansas City, Mo. | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | 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 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | 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.) | |
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____ | | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____ | |
| 21. I attended the deceased from Oct 1962 to 1-5-63 and last saw him ^{her} alive on 1-5-63 Death occurred at 4:00 PM on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE Laheem md (Degree or title) | | 22b. ADDRESS 409 Prof. Bldg. K. C. Mo. | |
| 22c. DATE 1-18-63 | | 22d. DATE SIGNED | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 1-22-1963 | |
| 23c. NAME OF CEMETERY OR CREMATORY National Cemetery | | 23d. LOCATION (City, town, or county) Fort Leavenworth, Kansas | |
| 24. FUNERAL DIRECTOR Sheil Funeral Home, K. C. Mo. ADDRESS _____ | | 25. DATE RECD. BY LOCAL REG. 1-21-63 | |
| 26. REGISTRAR'S SIGNATURE Ruth Long | | | |

USE BLACK INK OR TYPEWRITER RIBBON

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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 J. P. Shiel

Licensed Embalmer No. 3625

P. O. Address K. C. 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.

Faint text at the bottom of the page, possibly bleed-through or additional notes.