

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-028286

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3611 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

VS 300 Rev. 4/59	DATE AMENDED	
1	DATE AMENDED	
2	DATE AMENDED	
3	DATE AMENDED	
4	DATE AMENDED	
5	DATE AMENDED	
6	DATE AMENDED	
7	DATE AMENDED	
8	DATE AMENDED	
9	DATE AMENDED	
10	DATE AMENDED	
11	DATE AMENDED	
12	DATE AMENDED	
13	DATE AMENDED	

**FILED JUL 22 1963**

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>WYANDOTTE</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		c. CITY OR TOWN <b>KANSAS CITY</b>	
Length of stay in lb <b>5 wks</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>Hyde Park Nursing Home</b>		d. STREET ADDRESS (If outside, give location) <b>940 Ohio</b>	
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>HENRY</b> Last <b>FAHERTY</b>		4. DATE OF DEATH Month <b>June</b> Day <b>27</b> Year <b>1963</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</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>11/26/1881</b>
9. AGE (last birthday) <b>81</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carmen</b>	
11. BIRTHPLACE (City and state or country) <b>Sherman, Texas</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Austin Faherty</b>		13b. MOTHER'S MAIDEN NAME <b>Rose McAnn</b>	
14. NAME OF HUSBAND OR WIFE <b>RUBY</b>		17. INFORMANT <b>Mr Leo L. Faherty</b> Address <b>1708 N. 46th K.C.K</b>	
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.	
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>Broncho pneumonia</b> <b>Advanced Arteriosclerosis</b> 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 <b>3 days</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Pyelonephritis</b>			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
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.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>June 9, 1963</b> to <b>6/27/63</b> and last saw him alive on <b>June 25, 1967</b> Death occurred at <b>11:20 PM</b> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Wm. H. Goodson, Jr. M.D.</b>		22b. ADDRESS <b>Prof. Bldg K.C.Mo. 1322</b>	
22c. DATE SIGNED <b>6/28/63</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Highland Park Cemetery</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		23b. DATE <b>7/1/63</b>	
23d. LOCATION (City, town, or county) (State) <b>K.C.Ks.</b>		24. FUNERAL DIRECTOR <b>JOS. A. BUTLER'S SONS</b> ADDRESS <b>KCK</b>	
25. DATE RECD. BY LOCAL REG. <b>6-28-63</b>		26. REGISTRAR'S SIGNATURE <b>Ruth Song</b>	

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

00218  
/

0  
2  
1  
8

0-28

**STATEMENT BY LICENSED EMBALMER**

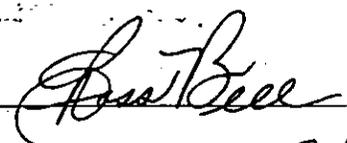
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

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

Signed \_\_\_\_\_



Licensed Embalmer No. 3476 Mo

P. O. Address Kennett, Kansas

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.