

SEP 10 1939  
Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No. **3204**

1. PLACE OF DEATH:

(a) County **Jackson**  
(b) City or town **Kansas City**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**K. C. Gen. Hospital No. 1**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **9 days**  
(Specify whether  
In this community **65 yrs.**  
years, months or days)

3. (a) PRINT FULL NAME **GEORGE FAUSSET**

**230**

3. (b) If veteran, name war **No**  
3. (c) Social Security name **None**

4. Sex **Male**  
5. Color **White**  
6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased **Sept 15 1872**  
(Month) (Day) (Year)

8. AGE: Years **67** Months **10** Days **25**  
If less than one day hr. \_\_\_\_\_ min.

9. Birthplace **Missouri**  
(City, town, or county) (State or foreign country)

10. Usual occupation **W.P.A. Laborer**

11. Industry or business

MOTHER FATHER  
12. Name **Austin Faussett**  
13. Birthplace **Indiana**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Margaret Clingmith**  
15. Birthplace **Ind.**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Chas. Faussett**  
(b) Address **1539 North Monroe**

17. (a) **Burial** (b) Date thereof **Aug 13 1940**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Greenlawn Cem.**

18. (a) Signature of funeral director **Mrs. C.L. Forster**  
(b) Address **918 Brooklyn Kansas City Mo.**

19. (a) **Aug. 13, 1940** (b) **M.M. Crowe**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**  
(c) City or town **Kansas City**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **1539 N. Monroe**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug.** day **10th**  
year **1940** hour **4** minute **50 P.** M.

21. I hereby certify that I attended the deceased from **8-1-40**, 19, to **8-10-40**, 19, that I last saw him alive on **8-10-40**, 19, and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary occlusion**

Due to **Heart disease hypertensive with nephritis Chron**

Due to **131**  
Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings: Of operations  
Of autopsy **See above**  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (c) Means of injury  
23. Signature **Dwight P. Thorn** (M. D. or other)  
Address **Med. Dir. K.C. Gen. Hospital** Date signed

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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 Me

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed G. H. Nune

Licensed Embalmer No. 2570

P. O. Address RC 5ms

**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 this body is not embalmed, above space should be left blank.**