

S. No. 2
M-9441
ev. 5-17-39
X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

3388

State File No.

Registration District No. 63

Primary Registration District No. 6266

Registrar's No. K

93
20
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
 (a) County St. Clair
 (b) City or town Osceola
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community 10 years
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County St. Clair
 (c) City or town Osceola
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Charles Hee Fait
 (b) If veteran, name war No
 (c) Social Security No. None

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month January day 24
 year 1942 hour 2:30 P.M. minute _____ M.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
 7. Birth date of deceased: 4- (Month) 29- (Day) 1881 (Year)

21. I hereby certify that I attended the deceased from 11: A.M. Friday
morning, 1942, to 2:30 P.M., 1942.
 that I last saw him alive on 1/24/42 11: P.M., 1942,
 and that death occurred on the date and hour stated above.

8. AGE: Years 60 Months 8 Days 25 If less than one day
 hr. _____ min. _____

Immediate cause of death Apoplexy due to cerebral hemorrhage.
 Duration _____

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

Due to Hypertension
 Due to Cerebral hemorrhage.

10. Usual occupation Farming

Other conditions (include pregnancy within 3 months of death)
 Major findings: 8301
 Of operations _____
 Of autopsy _____

11. Industry or business _____

MOTHER FATHER
 12. Name Matthew Fait
 13. Birthplace Kentucky (City, town, or county) (State or foreign country)
 14. Maiden name Unknown
 15. Birthplace Iowa (City, town, or county) (State or foreign country)

PHYSICIAN
 Underline the cause to which death should be charged statistically.

16. (a) Informant Elizabeth Fait
 (b) Address Osceola Mo

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof I-27-1942 (Month) (Day) (Year)
 (c) Place: burial or cremation Paradise Mo.

(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? _____

18. (a) Signature of funeral director Osceola Funeral Home
 (b) Address Osceola Mo

While at work? _____ (Specify type of place) Means of injury _____
 23. Signature Dr. D. F. Sears (M. D. or other) D.O.
 Address Osceola, Mo. Date signed 1/24/42

19. (a) 1-26-42 (Date received local registrar) (b) Dorothy Seeger (Registrar's signature)

1102

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 7,

District File Number 2-42-37

Date Filed 2-9-42

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

Signed.....

J. B. Goodrich

Licensed Embalmer No. 3038

P. O. Address Ossola 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 this body is not embalmed, fact should be so stated above.