7. S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 20 1944

Registration District No. 149

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 36695

Primary Registration District No. 1002

Registrar's No. 4520

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: St Joseph Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 0 (Specify whether years, months or days) In this community: 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State: MO (b) County: Jackson
(c) City or town: Kansas City (If outside city or town limits, write "RURAL")
(d) Street No.: 3408 Prospect (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: EUGENE E. FABIAN
3. (b) If veteran, name war: no
3. (c) Social Security No.: no

4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: Ken Angun
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: Sept (Month) 28 (Day) 1884 (Year)

8. AGE: Years 60 Months 1 Days 8 If less than one day hr. min.

9. Birthplace: Kansas City (City, town, or county) Kansas (State or foreign country)
10. Usual occupation: Pharmacist
11. Industry or business: Drug Store

FATHER
12. Name: John J. Fabian
13. Birthplace: Austria (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Katherine Falb
15. Birthplace: Austria (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs H.W. Fabian
(b) Address: 3756 Walash - K.C. Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 11-7-44 (Month) (Day) (Year)
(c) Place: burial or cremation: Mt Hope - K.C. Mo.
18. (a) Signature of funeral director: Gilbreath-Wernes
(b) Address: Kansas City Kans
19. (a) 11-9-44 (Date received local registrar) (b) D.E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Nov day: 6 year: 1944 hour: 8 P.M. minute: — M.
21. I hereby certify that I attended the deceased from: Pathologist, 19..; that I last saw h. alive on: 19..; and that death occurred on the date and hour stated above.

Immediate cause of death: Rupt Cerebral hemorrhage — Duration
Due to: Generalized arteriosclerosis
Due to:
Other conditions: Cardiac hypertrophy and dilatation
(Include pregnancy within 3 months of death)
Major findings:
Of operations: —
Of autopsy: As above

PHYSICIAN — 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? (Specify type of place)
While at work? (e) Means of injury:

23. Signature: Lorraine Sherwood (M. D. or other)
Address: Pathologist Date signed: 11-7-44
St. Joseph Hospital, K.C., Mo.

(Licensed Embalmer's Statement on Reverse Side)

DEC 4 1944

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 Augustus C. Werner

Licensed Embalmer No. 2597

P. O. Address 1734 Washington Blvd

Kansas City, 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 this body is not embalmed, fact should be so stated above.