

FILED FEB 6 1945

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1091

State File No. _____

276

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. _____

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:
1645 Myrtle
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
In this community #. 1 month / (Specify whether years, months or days)

3. (a) PRINT FULL NAME Brenda Sue Faubion

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Femal / 5. Color or race 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 Nov. 1 1944
(Month) (Day) (Year)

8. AGE: Years 0 Months 2 Days 18 / If less than one day hr. min.

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

10. Usual occupation Infant

11. Industry or business _____

MOTHER FATHER

12. Name Roy Emery Faubion

13. Birthplace Missouri / (City, town, or county) (State or foreign country)

14. Maiden name Bethel Schoneweather

15. Birthplace Missouri / (City, town, or county) (State or foreign country)

16. (a) Informant Roy Emery Faubion

(b) Address 1645 Myrtle

17. (a) Removal (b) Date thereof Jan 18 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sheldon Missouri

18. (a) Signature of funeral director Mrs. C. L. Forster

(b) Address 918 Brooklyn

19. (a) 1-18-45 (b) P. E. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 1645 Myrtle 8
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 18
year 1945 hour 6:10 minute a M.

21. I hereby certify that I attended the deceased from _____, 19____; to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Broncho-pneumonia

Due to Influenza

Due to 33 b

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations History & Inspection

Of autopsy not

Duration

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? _____

While at work? _____
(Specify type of place) (e) Means of injury

23. Signature James Walker (M. D. or other) Conner

Address 1424 N. 2nd St. Joplin Date signed 1-18-45

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

Signed E. H. Wise
Licensed Embalmer No. 2570
P. O. Address K C W

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.