. S. No. 2
M—9-4-41
ev. 5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 5 1945

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 9164

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 332

**1. PLACE OF DEATH:**

(a) County Buchanan
(b) City ~~or town~~ St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital No. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 month 8 days (Specify whether
In this community 1 month 8 days
years, months or days)

**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. 4610 Summit
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME FRANK FALLIN
3. (b) If veteran, name war None
3. (c) Social Security No. 495-03-7458
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced married
6. (b) Name of ~~husband or~~ wife Elsie May Fallin
6. (c) Age of ~~husband or~~ wife if alive not known years
7. Birth date of deceased 11 (Month) 22 (Day) 1886 (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---|---|---|---|---|
| | 58 | 4 | 0 | hr. min. |

9. Birthplace Lewisport (~~City~~, town, or county) Kentucky (State or ~~foreign country~~)
10. Usual occupation Carpenter
11. Industry or business Railroad
FATHER
12. Name Thomas Fallin
13. Birthplace Unknown (City, town, or county) Kentucky (State or ~~foreign country~~)
MOTHER
14. Maiden name Mattie Roberts
15. Birthplace Unknown (City, town, or county) Kentucky (State or ~~foreign country~~)
16. (a) Informant Melford Fallin
(b) Address 4608 Summit - K.C. Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar. 26, 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park Cemetery
18. (a) Signature of funeral director D. H. Newcomer's Sons
(b) Address 1401 Brush Creek Blvd. K.C. Mo.
19. (a) 3-26-45 (Date received local registrar) (b) Helen I. Tickle (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month 3 day 22 year 1945 hour 8 minute 5 P.M.
21. I hereby certify that I attended the deceased from 2-14- 1945 to 3-22- 1945 that I last saw him alive on 3-22- 1945 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Cerebral arterio-sclerosis | 3 years |
| Due to Syphilis | 4 years |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |
| Major findings: Of operations | |
| Of autopsy | |

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 J. H. Marroway (M. D. ~~or other~~)
Address State Hospital No. 2 Date signed 3-22-45

1377

(Licensed Embalmer's Statement on Reverse Side)

APR 9 1943

MAR 17 1955

OCT 18 1955

## 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 H. C. Newcomer Jr.

Licensed Embalmer No. 4043

P. O. Address K. C. 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.**