V. 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 APR 23 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 12150

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1668

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:
921-CHERRY STREET-APT #1141
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ---
(Specify whether
In this community 5 MONTHS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON
(c) City or town KANSAS CITY 48
(If outside city or town limits, write "RURAL")
(d) Street No. 921-CHERRY STREET 3
(If rural, give location)
(e) Citizen of foreign country? NO 0 (Yes or No)
If yes, name country ---

3. (a) PRINT FULL NAME SHARON JAUNITA FAUL

3. (b) If veteran, name war NO

3. (c) Social Security No. NONE

4. Sex FEMALE 1

5. Color or race WHITE

6. (a) Single, widowed, married, divorced SINGLE 0

6. (b) Name of husband or wife ---

6. (c) Age of husband or wife if alive --- years

7. Birth date of deceased DECEMBER-25-1943
(Month) (Day) (Year)

8. AGE: Years 1 Months 3 Days ~~15~~ 14 If less than one day hr. min.

9. Birthplace HARVEY (City, town, or county) NORTH DAKOTA (State or foreign country) 1

10. Usual occupation INFANT

11. Industry or business ---

FATHER
12. Name LIEUT CHESTER R. FAUL 1
13. Birthplace (City, town, or county) NORTH DAKOTA (State or foreign country)

MOTHER
14. Maiden name JUANITA FOSTER 1
15. Birthplace (City, town, or county) KANSAS 1 (State or foreign country)

16. (a) Informant MRS. CHESTER R. FAUL
(b) Address 921-CHERRY STREET

17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof APR-13-1945 (Month) (Day) (Year)
(c) Place: burial or ~~cremation~~ HARVEY NORTH DAKOTA

18. (a) Signature of funeral director D. H. Newcomer & Sons
(b) Address 1401-BRUSH CREEK BLVD.

19. (a) 4-13-45 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 9TH
year 1945 hour 8 minute 45 P. M.

21. I hereby certify that I attended the deceased from April 8, 1945, to April 9, 1945
that I last saw her alive on April 8, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death
Pneumonia
Bronchial

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death) 107

Major findings:
Of operations

Of autopsy

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?
(Specify type of place)
While at work? (e) Means of injury 0

23. Signature Harold A. Pallett (M. D. or other) M.D.
Address 1132 Prof. Bldg. Kansas Date signed 4/10/45

(Licensed Embalmer's Statement on Reverse Side)

11:32 Professional Bldg
11:30-5:30

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. Oscar Worthy

Licensed Embalmer No. 1967

P. O. Address Kansas City

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.