

FILED DEC 5 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **36246**  
Registrar's No. **54**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **15** PRIMARY REG. DIST. NO. **3004**

1. PLACE OF DEATH a. COUNTY <b>Barton</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Barton</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Lamar</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Milford</b>	
c. LENGTH OF STAY (in this place) <b>3 months</b>		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>1301 Poplar</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Elizabeth</b> b. (Middle) <b>V.</b> c. (Last) <b>Faubion</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Nov. 13, 1949</b>
---	---

5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>Aug. 11, 1869</b>	9. AGE (In years last birthday) <b>80</b>	IF UNDER 1 YEAR Months _____ Days _____	IF OVER 1 YEAR Hours _____ Mins. _____
----------------------	-------------------------------	---	---------------------------------------	---	--	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Same</b>	11. BIRTHPLACE (State or foreign country) <b>Milford, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
--	---	---	--

13a. FATHER'S NAME <b>G. W. Crowley</b>	13b. MOTHER'S MAIDEN NAME <b>Elizabeth V. Buster</b>	14. NAME OF HUSBAND OR WIFE <b>Deceased</b>
---	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Sam Garrison</b>	ADDRESS <b>Lamar, Mo.</b>
--	-------------------------------------	--	---------------------------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH  <b>331X</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Hemorrhage</b>		
	ANTECEDENT CAUSES *Forbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) <b>Hypostatic Pneumonia</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	----------------------------------	---

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
--	--	----------------------------

22. I hereby certify that I attended the deceased from **Oct 4, 1949** to **11-13, 1949**, that I last saw the deceased alive on **Nov 13, 1949**, and that death occurred at **1:45 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>H. M. Arnold M.D.</b>	23b. ADDRESS <b>Lamar, Mo.</b>	23c. DATE SIGNED <b>11-14-49</b>
---	--------------------------------	----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>11/15/49</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Howell Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Milford, Mo.</b>
---	---------------------------	---	---

DATE REC'D BY LOCAL REG. <b>11-14-49</b>	REGISTRAR'S SIGNATURE <b>Marie Korantz</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Clarence W. Chiles</b>	ADDRESS <b>Lamar, Mo.</b>
--	--	--	---------------------------

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

RECEIVED NOV 21 1949

District Health Office No. 6,

District File Number 1149-1256

Date Filed 11-28-49

NOV 21 1949

District Health Office No. 6,

District File Number \_\_\_\_\_

Date Filed \_\_\_\_\_

---

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

*Chas. W. Gules*

Signed \_\_\_\_\_

Student Embalmer

Licensed Embalmer No. 3473

P. O. Address \_\_\_\_\_

*Home 7700*

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.