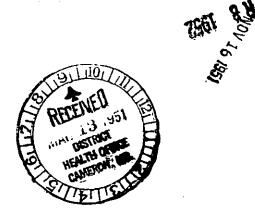
FILED MAR 19 1951 s	- ,			11389			
		•		9			
I. PLACE OF DEATH a. COUNTY Worth		2 USUAL RESIDENCE a. STATE Missouri	(Where deceased lived. If inst b. COUNTYWOT	titution: residence before admission).			
b. CITY (If outside corporate limits, write RURAL and give C. LENGTH OF STAY (in this place) TOWN Grant City		c. CITY (If outside corporate limits, write RURAL and give township) //30 OR TOWN Grant City					
d. FULL NAME OF (If not in hospital or institution HOSPITAL OR INSTITUTION		d. STREET (If run ADDRESS	al, give location)	i			
3. NAME OF a. (First) DECEASED (Type or Print) IBBiah	b. (Middle) Wakefield	c. (Last) Faubion	4. DATE - (Month) OF DEATH 2	(Day) (Year) 26 1951			
_ /) w	(IDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 9 28 1873	9. AGE (In years IF UNDER last birthday) Months	Pays Hours Min.			
done during most of working life, even if retired)	DUSTRY		/\ /\	12. CITIZEN OF WHAT COUNTRY?			
13a. FATHER'S NAME Jacob Smith Faubion							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY 17. INFORMANT'S SIGNATURE OR NAME ADDRESS (You, no, or unknown) (If you, give war or dates of service) none NO. NO. Mrs. Lyda E. Faubion Grant City, Mo.							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) 11. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MEDICAL CERTIFICATION INTERVAL 1 ONSET AND							
*This does not mean the mode of dying, such Morbid conditions, if any, giving DUE TO (b)							
as heart failure, asthenia, citc. It means the discussion of the underlying cause last. DUE TO (c) DUE TO (c)							
tion which caused death. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Fasalysing type that the disease or condition causing death.							
19a. DATE OF OPERA- 19b. MAJOR FINDINGS	OF OPERATION			20. AUTOPSY1			
		21c. (CITY, TOWN, OR TOWNSH	(COUNTY)	(STATE)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY m.	WHILE AT NOT WHILE WORK AT WORK	21f, HOW DID INJURY OCCUR	1 	. ,			
22. I hereby certify that I attended the deceased from 200 , 1851, to 26750, 1951; that I last saw the deceased alive on 2556, 1951, and that death occurred at 50 m., from the causes and on the date stated above. 23a. SIGNATURE: (Degree or tille) 23b. ADDRESS A							
30. SIGNATURE & Uga	Et Exon Wind	23b. ADDRESS	aty	23c. DATE SIGNED			
Z4a. BURIAL. CREMA- TION, REMOVAL (Specify) Durial // 2 28 1951		etery Gran		ty) (State)			
Mar. 9.1939 Tota Dawson I Joch C. Dungel Grant City, No.							
	I. PLACE OF DEATH a. COUNTY Worth b. CITY (If outside corporate limits, write RURAL OR TOWN Grant City d. FULL NAME OF (If not in hospital or institution HOSPITAL OR INSTITUTION 3. NAME OF DECEASED (Type or Print)	BIRTH MO. I. PLACE OF DEATH a. COUNTY Worth b. CITY (If outside corporate limits, write RURAL and give CONTROLOGY) GR Grant City d. FULL NAME OF (If not in bospital or institution, give street address or location) INSTITUTION 3. NAME OF (If not in bospital or institution, give street address or location) INSTITUTION 3. NAME OF (If not in bospital or institution, give street address or location) INSTITUTION 3. NAME OF (If not in bospital or institution, give street address or location) INSTITUTION 3. NAME OF (If not in bospital or institution, give street address or location) INSTITUTION 3. NAME OF (If not in bospital or institution, give street address or location) INSTITUTION 3. NAME OF (If not in bospital or institution, give street address or location) INSTITUTION 3. NAME OF (If not in bospital or institution, give street address or location) INSTITUTION 3. NAME OF (If not in bospital or institution, give street address or location) INSTITUTION 3. NAME OF (If not in bospital or institution, give street address or location) INSTITUTION 3. NAME OF (If not in bospital or institution, give street address or location) INSTITUTION 3. NAME OF (If not in bospital or institution, give street address or location) INSTITUTION 3. NAME OF (If not in bospital or institution, give street address or location) INSTITUTION 3. NAME OF (If not in bospital or institution, give street address or location or name or location or name or not not not not provided in the name of the name or location or name or location or name or nam	I. PLACE OF DEATH a. COUNTY Worth b. CITY (II outside corporate limits, write RURAL and give cownship) TOWN Grant City d. FULL NAME OF CIT out in hospital or institution, give street address or location HOFFALOR 3. NAME OF CIT out in hospital or institution, give street address or location HOFFALOR 3. NAME OF DECEASED 6. COLOR OR RACE (Type or Print) 15. SEX 10. USUAL OCCUPATION (Give land of von): MILE OF PRINTING OF BUSINESS OR IN- COLOR OF Print) 15. WAS DECEASED EVER IN U. S. ARMED FORCES! (S. SOCIAL SECURITY NO. OR OR OR COMMON OF COMM	STANDARD CERTIFICATE OF DEATH Stear File No BIRTH NO BEG. DIST. NO. 374 PRIMARY REG. DIST. NO. 4547 Registror's No 1. PLACE OF DEATH a. COUNTY Worth b. CITY (If contaids componies limits, write RURAL and give township) d. FULL MINE OF (If not in boughtal or inatinulos), circ street educate or location of INSTITUTION 3. NAME OF 3. SEXT MISSOURI C. CITY (If contaids componies limits, write RURAL and give township) 3. SEX (Institution) 4. DATE (Month) COUNTY (Institution) 6. COLOR OR RACE (Institution) 10. SEX (Institution) 10.			



STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this c	ertificate	was embali	ned by me, (or by
	Student	Embalmer	No	·^
working under my personal supervision.	_			

Licensed Embalmer No...

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.