

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED AUG 9 1952

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 144 PRIMARY REG. DIST. NO. 3032 Registrar's No. 107

0512

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

1. PLACE OF DEATH a. COUNTY <b>Johnson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Johnson</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Warrensburg</b>		c. LENGTH OF STAY (In this place) <b>1 day</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Warrensburg Medical Center</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rural Chilhowee</b>	
		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Gertrude</b>	b. (Middle) <b>Blanche</b>	c. (Last) <b>Faulwell</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Aug. 2, 1952</b>
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5. SEX <b>Fe</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Sept. 3, 1896</b>	9. AGE (In years last birthday) <b>55</b>	IF UNDER 1 YEAR Days <b>10</b>	IF UNDER 24 HRS. Hours <b>30</b>	Min.
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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>X</b>	11. BIRTHPLACE (State or foreign country) <b>Cooper Co., Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Jonah L. Decker</b>	13b. MOTHER'S MAIDEN NAME <b>Appilonia Shafer</b>	14. NAME OF HUSBAND OR WIFE <b>Leslie R. Faulwell</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. <b>X</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Leslie R. Faulwell, Chilhowee, Mo.</b>	ADDRESS
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral vascular accident</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs.</b>
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hypertensive cardiovascular disease</b>		
	DUE TO (c)		
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 <b>443 X</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 5-2-1952, to 7-26-1952, that I last saw the deceased alive on 8-2-1952, and that death occurred at 6:30 A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Charles M. Sedener, M.D.</b>	23b. ADDRESS <b>Warrensburg, Mo.</b>	23c. DATE SIGNED <b>8-4-52</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Aug 3, 1952</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Sunset Hill</b>	24d. LOCATION (City, town, or county) (State) <b>Warrensburg, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>Aug 4, 1952</b>	REGISTRAR'S SIGNATURE <b>Savannah</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Cook Funeral Home, Chilhowee, Mo.</b>	ADDRESS
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AUG 5 1952  
RECEIVED

JOHNSON COUNTY HEALTH DEPT

MS SEP 17 1959

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.

*J.W. Cool*  
Licensed Embalmer No. 4335

Signed.....

Student .....  
Student Embalmer

P. O. Address Chilhowee, Missouri.

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.