

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

30810

State File No. ....

FILED SEP 22 1952

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 12 PRIMARY REG. DIST. NO. 1000 Registrar's No. 972

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>	
c. LENGTH OF STAY (in this place) <u>29 yrs</u>		d. STREET ADDRESS (If rural, give location) <u>1610 Buchanan Ave.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1610 Buchanan Ave.</u>		e. STREET ADDRESS <u>1610 Buchanan Ave.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Cephus</u> b. (Middle) <u>Charles</u> c. (Last) <u>McFadden</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>September 9, 1952</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>September 23, 1871</u>	9. AGE (In years last birthday) <u>80</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (State or foreign country) <u>Streator, Illinois.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>

13a. FATHER'S NAME <u>George McFadden</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Boyd</u>		14. NAME OF HUSBAND OR WIFE <u>Nellie McFadden</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) ***** <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. C. B. Archibald St. Joseph, Mo.</u>	

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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Accident</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis Gen</u> DUE TO (c) <u>Phlebitis &amp; Thrombosis lower Extremities</u>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>46.4 X</u>		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 6-17, 1950, to 9-9, 1952, that I last saw the deceased alive on 9-9, 1952, and that death occurred at 6:15 Pm., from the causes and on the date stated above.

23a. SIGNATURE <u>R. W. Kieber, M.D.</u> (Degree or title)		23b. ADDRESS <u>Phys. Surg. Bldg - City</u>		23c. DATE SIGNED <u>9-11-52</u>	
24a. BURNAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Sept. 12, 1952</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Mora Cemetery</u>	
24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Missouri.</u>					

DATE REC'D BY LOCAL REG. <u>Sept 17, 1952</u>		REGISTRAR'S SIGNATURE <u>Carl C. Casper</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Walter Meuchner St. Joseph, Mo.</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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-----\*\*\*\*\*

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Student Embalmer No. ....\*\*\*\*\*

working under my personal supervision.

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Student .....  
Student Embalmer

Signed

*Raymond W. Morehead*

Licensed Embalmer No. ....4413 Missouri.....

P. O. Address.....St. Joseph, 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.