

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **42257**  
**5463**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>KANSAS CITY</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Kansas City</b>	
c. LENGTH OF STAY (In this place) <b>4 yrs.</b>		d. STREET ADDRESS (If rural, give location) <b>C. E. 42nd. St. 3679</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>4E. 42 St. K. C. Missouri</b>			

3. NAME OF DECEASED (Type or Print) <b>KRESZEN Z</b>		a. (First) <b>(n)</b>	b. (Middle) <b>(n)</b>	c. (Last) <b>FASCHING</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>DEC. 12, 1952</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>OCT. 15, 1869</b>	9. AGE (In years last birthday) <b>83</b>	IF UNDER 1 YEAR: Months <b>27</b> Days _____ Hours _____ Min. _____
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>none</b>		11. BIRTHPLACE (State or foreign country) <b>BADEN, GERMANY</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>

13a. FATHER'S NAME <b>ANDREW EBERHART</b>		13b. MOTHER'S MAIDEN NAME <b>THERESA SNIDER</b>		14. NAME OF HUSBAND OR WIFE <b>JOSEPH FASCHING *DECEASED.</b>	
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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>NO</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Joseph Fasching 4E 43rd St KC 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cardiac Decompensation</b>		DUPLICATE OF (b) <b>arteriosclerotic heart</b>		<b>1 week</b>	
		ANTECEDENT CAUSES		DUPLICATE OF (c) <b>diabetes</b>		<b>5 years</b>	
		Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				<b>4200</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"/>	
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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 1941, 19  , to Dec 12, 1952, that I last saw the deceased alive on Dec 11, 1952, and that death occurred at 10:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE <b>John D. Skinner MD</b>		23b. ADDRESS <b>1102 Grand St. K.C. Mo.</b>		23c. DATE SIGNED <b>12-13-52</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		24b. DATE <b>12-12-1952</b>		24c. NAME OF CEMETERY OR CREMATORY <b>MT. C ALVARY CEMETERY</b>		24d. LOCATION (City, town, or county) (State) <b>OLATHE, KANSAS.</b>	
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DATE REC'D BY LOCAL REG. <b>12-13-52</b>		REGISTRAR'S SIGNATURE <b>Sheralding Smith</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Martin W. Ture</b>		ADDRESS <b>Olathe, Mo.</b>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

*J. D. [unclear]*

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 \_\_\_\_\_

*Martin W. Dyer*

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

working under my personal supervision.

Student .....  
Student Embalmer

Signed *Martin W. Dyer*

Licensed Embalmer No. *2615*

P. O. Address *Olathe, Ks*

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.