S. No. 300
v. 10-48

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

FILED OCT 13 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31045**

BIRTH NO. 58643 REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1066

1. PLACE OF DEATH
a. COUNTY: Buchanan
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Joseph
c. LENGTH OF STAY (in this place): 6hrs-13min.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: DeKalb
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Clarksdale
d. STREET ADDRESS (If rural, give location): 0320 / 1

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
KAREN	LYNN	FAGAN	Sept. 13, 1953

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
1 Female	White	Never married	Sept. 13, 1953				6	13

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		St. Joseph, Mo.	USA

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
Dwayne Fagan	Geneva Burris	None

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS
no	None	Dwayne Fagan, Clarksdale, Mo.

MEDICAL CERTIFICATION

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, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Congenital Atelectasis	6 hrs.
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Prematurity	
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	20. AUTOPSY?
	7625	YES ☐ NO ☒

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)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Sept 13, 1953, *to* Sept 13, 1953, *that I last saw the deceased alive on* Sept 13, 1953, *and that death occurred at* 2:15 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Charles F. Shulen M.D.	902 Edmond St., City	9-22-53

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept 14, 1953	Clarksdale	Clarksdale, Mo.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
Oct 6, 1953	Esther M. Allison 485 D	John Bram Maysville Mo.

(Licensed Embalmer's Statement on Reverse Side)

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.

Student .....
Student Embalmer

Signed John Brown

Licensed Embalmer No. 3933

P. O. Address Maysville Mo

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.