

No. 300
10.48

STANDARD CERTIFICATE OF DEATH

State File No. **7634**

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BIRTH **DECEASED MAR 16 1954** REG. DIST. NO. **2** PRIMARY REG. DIST. NO. **5010** Registrar's No. **14**

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

3. NAME OF DECEASED (Type or Print)		a. (First) Chester		b. (Middle) Arthur		c. (Last) Faires		4. DATE OF DEATH (Month) (Day) (Year) 2-28-1954	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH 10-13-1877		9. AGE (In years last birthday) Months Days 74 4 13	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Andrew Co Mo		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Manley Faires		13b. MOTHER'S MAIDEN NAME Ella Burns		14. NAME OF HUSBAND OR WIFE Lula Belle Faires	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Lula B. Faires Bolckow Mo	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
<p>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebrovascular Accident				5 min	
		ANTECEDENT CAUSES					
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (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		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) 331X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		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 **2-28, 1954**, to **2-28, 1954** that I last saw the deceased alive on _____, 19____, and that death occurred at **5:15 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Warren C. Baker MD		23b. ADDRESS Savannah Mo.		23c. DATE SIGNED 3-1-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 3-2-1954		24c. NAME OF CEMETERY OR CREMATORY SAVANNAH	
24d. LOCATION (City, town, or county) (State) SAVANNAH Mo		DATE REC'D BY LOCAL REG. 3-1-54		REGISTRAR'S SIGNATURE Lillian Sparks	
25. FUNERAL DIRECTOR'S SIGNATURE Breit Funeral Home		ADDRESS SAVANNAH Mo			

(Licensed Embalmer's Statement on Reverse Side)

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

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 E. C. Breit

Licensed Embalmer No. 2650

P. O. Address Swanton, Ind

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.