

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

7917

State File No. ....

BIRTH NO. FILED APR 12 1954 REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008 Registrar's No. 94

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY Callaway   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.)<br>a. STATE Missouri b. COUNTY Callaway |  |  |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN Fulton  |  | c. LENGTH OF STAY (In this place)<br>4 1/2 Hrs   |  | c. CITY OR TOWN Fulton   |  | d. Is Residence within limits of a city or incorporated town?<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Callaway Co., Hospital  |  |  |  | e. STREET ADDRESS (If rural, give location)<br>730 Bluff St., 0143   |  |  |  |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) William   |  | b. (Middle) L.   |  | c. (Last) Fait   |  | 4. DATE OF DEATH (Month) (Day) (Year)<br>April 7 1954  |  |
| 5. SEX Male   |  | 6. COLOR OR RACE White   |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married   |  | 8. DATE OF BIRTH<br>Sept-20-1868   |  |
| 9. AGE (In years last birthday) 85  |  | 10. MONTHS 5   |  | 11. HOURS 17   |  | 12. CITIZEN OF WHAT COUNTRY? U.S.A.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, except if retired) Retired Pattern Maker   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY Fire Brick Co  |  | 11. BIRTHPLACE (City and State or Foreign Country) Oden Indiana  |  |
| 13a. FATHER'S NAME<br>Isaiah Fait   |  | 13b. MOTHER'S MAIDEN NAME<br>Annie Sears   |  | 14. NAME OF HUSBAND OR WIFE<br>Elizabeth B. Fait   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No  |  | 16. SOCIAL SECURITY (If yes, give war or dates of service) 498-09-1924   |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br>Mrs. Wm. L. Fait Fulton, Mo.  |  |  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage<br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) Arteriosclerosis<br>DUE TO (c)<br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br>6 hrs<br>?   |  |
| 19a. DATE OF OPERATION  |  | 19b. MAJOR FINDINGS OF OPERATION   |  |  |  | 20. AUTOPSY?<br>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 1946, to 4-7, 1954, that I last saw the deceased alive on 4-7-1954, and that death occurred at 5:30 p. m., from the causes and on the date stated above.                 |  |  |  |  |  |  |  |
| 23a. SIGNATURE (Degree or title)<br>Joseph Brown M.D.   |  |  |  | 23b. ADDRESS<br>Fulton, Mo.  |  | 23c. DATE SIGNED<br>4-9-54   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial  |  | 24b. DATE<br>Apr-10-1954   |  | 24c. NAME OF CEMETERY OR CREMATORY<br>Hillcrest  |  | 24d. LOCATION (City, town, or county) (State)<br>Fulton Mo   |  |
| DATE REC'D BY LOCAL REG.<br>Apr. 9-1954   |  | REGISTRAR'S SIGNATURE<br>Martha Lawrence 426-  |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br>Wallace Funeral Home, Fulton Mo  |  |  |  |

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10.48

---

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.....  
Signature of Student Embalmer

Signed *William E. Green*

Licensed Embalmer No. *48*

P. O. Address *Hutto*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.