

FILED JUL 19 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22214**

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **5134** Registrar's No. **754**

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Route #1 Wash Twsp		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Route #1, Washington Twsp	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3 Miles East & 3 Miles n.		d. STREET ADDRESS (If rural, give location) 3 Miles East & 3 Miles north of St. Joseph, Mo	

3. NAME OF DECEASED (Type or Print)	a. (First) ALFRED	b. (Middle) LEO	c. (Last) FANKHAUSER	4. DATE OF DEATH (Month) (Day) (Year) July 7th 1954
-------------------------------------	--------------------------	------------------------	-----------------------------	--

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married-	8. DATE OF BIRTH September 28-1878	9. AGE (In years last birthday) 75 Yrs	IF UNDER 1 YEAR Months Days	IF UNDER 6 HRS. Hours Min.
--------------------	-------------------------------	--	---	---	-----------------------------	----------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer; Retired	10b. KIND OF BUSINESS OR INDUSTRY Gen. Farming.	11. BIRTHPLACE (State or foreign country) Buchanan, Co. Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	--	---	--

13a. FATHER'S NAME Peter Fankhauser	13b. MOTHER'S MAIDEN NAME Barbara Guyman	14. NAME OF HUSBAND OR WIFE Mrs. Carrie Fankhauser
--	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No none	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Carrie Fankhauser, (wife), R. R. #1 St. Joseph, Mo.
---	-------------------------------------	---

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		INTERVAL BETWEEN ONSET AND DEATH Wks wks months
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia Chf Myo car suscep. Cerebral Hemorrhage Aspergillus		
	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)
--	--	---

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 **6-30, 1954** to **7-7, 1954**, that I last saw the deceased alive on **7-6, 1954**, and that death occurred at **2:30a m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Dr. F. H. Sisson	23b. ADDRESS St. Joseph, Mo.	23c. DATE SIGNED 7-7-54
--	-------------------------------------	--------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) (Burial)	24b. DATE July 9-1954	24c. NAME OF CEMETERY OR CREMATORY Oak Ridge Cemetery	24d. LOCATION (City, town, or county) (State) Cosby, Missouri
---	------------------------------	--	--

DATE REC'D BY LOCAL REG. July 10, 1954	REGISTRAR'S SIGNATURE Kathleen M. Allison	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Muehlhoff Funeral Home St. Joseph, Mo.
---	--	--

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

(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

Raymond W. Marchessault

Licensed Embalmer No.

4413

P. O. Address

St Joseph 520

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.