

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **30085**

FILED SEP 28 1954

BIRTH NO. _____ REG. DIST. NO. 71 PRIMARY REG. DIST. NO. 3012 Registrar's No. 98

1. PLACE OF DEATH a. COUNTY <u>Clay</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Kansas</u> b. COUNTY <u>Cherokee</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Excelsior Springs, Mo.</u>		c. LENGTH OF STAY (In this place) <u>2 days</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Columbus</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Veterans Administration Hospital Excelsior Springs, Missouri</u>			d. STREET ADDRESS (If rural, give location) <u>Route-2</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>FERRY</u>		b. (Middle) <u>S</u>	c. (Last) <u>FANCHER</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 8 1954</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never married</u>	8. DATE OF BIRTH <u>August 1, 1917</u>	9. AGE (In years last birthday) <u>37</u>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cleaner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cleaner-Self employed</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Baxter Springs, Kansas</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13a. FATHER'S NAME <u>James P. Fancher</u>		
13b. MOTHER'S MAIDEN NAME <u>Elsie James</u>			14. NAME OF HUSBAND OR WIFE _____		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>512 18 0223</u>		17. INFORMANT'S SIGNATURE OR NAME <u>VA Hospital records</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Tuberculosis, pulmonary, chronic, far adv. active.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES <u>Tuberculous laryngitis</u>			II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>
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) _____		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 <u>Sept 7</u> , 19 <u>54</u> , to <u>Sept. 8</u> , 19 <u>54</u> , that the death was the result of <u>X</u> and that death occurred at <u>6:10 p. m.</u> , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <u>S. C. STROFF, M. D.</u>			23b. ADDRESS <u>Excelsior Springs, Mo.</u>		23c. DATE SIGNED <u>9-10-54</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removed</u>		24b. DATE <u>9-10-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Excelsior Funeral Home, Columbus, Mo.</u>	
24d. LOCATION (City, town, or county) (State) _____		25. FUNERAL DIRECTOR'S SIGNATURE <u>Dr. Mrs. Paul Cannon, Mo.</u>		ADDRESS _____	
DATE REC'D BY LOCAL REG. <u>9-17-54</u>		REGISTRAR'S SIGNATURE <u>Barlene Hutchings</u>		ADDRESS _____	

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

Harold A. Walker

Licensed Embalmer No. *45-88*

P. O. Address *Lathrop, 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.