

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED AUG 29 1955

State File No. **25816**

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>726</u>			
1. PLACE OF DEATH a. COUNTY <b>GREENE</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b>				b. COUNTY <b>GREENE</b>	
b. CITY OR TOWN <b>SPRINGFIELD</b>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <b>SPRINGFIELD</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>1017 W CHASE</b>				e. STREET ADDRESS (If rural, give location) <b>1017 W. CHASE</b>				<u>0396</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>ALBERT</b>			b. (Middle) _____			c. (Last) <b>FAUGHT</b>			
4. DATE OF DEATH (Month) (Day) (Year) <b>AUG 18, 1955</b>			5. SEX <input type="radio"/> MALE <input checked="" type="radio"/> FEMALE			6. COLOR OR RACE <b>WHITE</b>			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>			8. DATE OF BIRTH <b>JULY 27, 1877</b>			9. AGE (In years last birthday) <b>78</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RET. FARMER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>RET. FARMER</b>			11. BIRTHPLACE (City and State or Foreign Country) <b>MISSOURI</b>			
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13a. FATHER'S NAME <b>JAMES FAUGHT</b>			13b. MOTHER'S MAIDEN NAME <b>LUCINDA MANARD</b>			
14. NAME OF HUSBAND OR WIFE <b>WIDOWED</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>Unknown</b>			
17. INFORMANT'S SIGNATURE OR NAME <b>LINSEY FAUGHT</b>			ADDRESS <b>BRIGHTON, MO.</b>			18. CAUSE OF DEATH			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral of Symplicol Colon</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>153x</u>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						
19a. DATE OF OPERATION <b>1953</b>			19b. MAJOR FINDINGS OF OPERATION <u>Cx of Symplicol</u>			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>May</u> , 19 <u>49</u> , to <u>8-18</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>8-17</u> , 19 <u>55</u> , and that death occurred at <u>10:00pm.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>Max T. Holt M.D.</u>			23b. ADDRESS <u>Springfield Mo</u>			23c. DATE SIGNED <u>8-20-55</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			24b. DATE <b>AUG. 21 1955</b>			24c. NAME OF CEMETERY OR CREMATORY <b>PAYNE CEMETERY</b>			
24d. LOCATION (City, town, or county) (State) <b>GREENE CO. MISSOURI</b>			DATE REC'D BY LOCAL REG. <u>8-23-55</u>			REGISTRAR'S SIGNATURE <u>Erita Williamson</u>			
25. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. ...</u>			ADDRESS <b>SPRINGFIELD, MO.</b>						

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

DEC 3 1958

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by ....., Student Embalmer No. ....

working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Max A. Ho...*.....

Licensed Embalmer No. *40*.....

P. O. Address *Spring*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.