

FILED MAY 15 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **12233**

BIRTH NO. _____		REG. DIST. NO. <b>4</b>		PRIMARY REG. DIST. NO. <b>4014</b>		Registrar's No. <b>46</b>	
1. PLACE OF DEATH a. COUNTY <b>ATCHISON</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY <b>ATCHISON</b>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>FAIRFAX</b>		c. LENGTH OF STAY (In this place) <b>12 hrs</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Rock Port, Mo</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>FAIRFAX COMMUNITY HOSP.</b>				d. STREET ADDRESS (If rural, give location) <b>0030</b>			
3. NAME OF DECEASED a. (First) <b>GEORGE</b>			b. (Middle) <b>HENRY</b>		c. (Last) <b>FANSELLER</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>5-5-1956</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>7-21-1890</b>	9. AGE (In years last birthday) <b>65</b>	IF UNDER 1 YEAR Months <b>9</b> Days <b>14</b>	IF UNDER 24 HRS. Hours <b>14</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GENERAL</b>		11. BIRTHPLACE (State or foreign country) <b>Rock Port, Mo</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13a. FATHER'S NAME <b>George H. Fassel</b>			13b. MOTHER'S MAIDEN NAME <b>Louisa Trout</b>		14. NAME OF HUSBAND OR WIFE <b>Nellis Hoover</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>488-14-4168</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Max Nellis Fassel, Rock Port, Mo</b>			
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 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Hemorrhage</b>					INTERVAL BETWEEN ONSET AND DEATH <b>18 hrs</b>
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Cerebral Arteriosclerosis</b>					<b>10 years</b>
		DUE TO (c)					
		11. 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 <b>331X</b>					20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 <b>May</b> , 19 <b>52</b> , to <b>5-5</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>5-5</b> , 19 <b>56</b> , and that death occurred at <b>6:30 P.M.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Walter Carpenter, M.D.</b>				23b. ADDRESS <b>Rock Port, Mo</b>		23c. DATE SIGNED <b>5-7-56</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>5-8-1956</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Summit Cem.</b>		24d. LOCATION (City, town, or county) (State) <b>Rock Port, Mo.</b>		
DATE REC'D BY LOCAL REG. <b>May 8, 1956</b>		REGISTRAR'S SIGNATURE <b>Merwin H. Schoeler</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Bartholomew Mastney</b>		ADDRESS <b>Rock Port, Mo</b>	

(Licensed Embalmer's Statement on Reverse Side)

9581 9 P. 14.

**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 Gert Borchert

Licensed Embalmer No. 3173

P. O. Address Rock Pt. mo

**Note:** The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to complete the above constitutes grounds for revocation of license.)

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