

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-008433

STATE FILE NUMBER

FILED APR 7 1959 Registration District No. 37 Primary Registration District No. 4049 Registrar's No. 14

300  
1-57

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Boone</b>  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY <b>Boone</b>                         |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Centralia</b>  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                  | c. CITY OR TOWN <b>Centralia</b> 0105   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>                |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>S. Jefferson St.</b>   | Length of stay in lb<br><b>1 week</b>   | d. STREET ADDRESS (If outside, give location)<br><b>601 S. Jefferson</b>  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                          |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>Maysel Faucett</b>  |   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>March 30 1959</b>  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 26, 1886</b>   |
| 9. AGE (In years last birthday)<br><b>72</b>   | IF UNDER 1 YEAR<br>Months Days<br><b>10 4</b>   | IF UNDER 24 HRS.<br>Hours Min.<br><b>4</b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (City and state or country)<br><b>Boone County, Mo.</b>  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |
| 13a. FATHER'S NAME<br><b>William H. White</b>  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Mary Louisa Button</b>  | 14. NAME OF HUSBAND OR WIFE<br><b>S.F. Faucett (deceased)</b>                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  | 16. SOCIAL SECURITY NO.<br><b>None</b>  | 17. INFORMANT<br><b>Mrs. W.C. Adams, Centralia, Mo.</b><br>Address  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic myocarditis</b>   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>8 days</b>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____   |   |   | 4221  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Cerebral thrombosis on February 16, 1959</b>   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2 |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)<br>----- |   |   |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m.<br>p.m.   | -----   |   |   |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>-----     | 20f. CITY, TOWN, OR LOCATION COUNTY STATE   |   |
| 21. I attended the deceased from <b>Feb. 17, 1959</b> to <b>30 Mar. 1959</b> and last saw <sup>her</sup> alive on <b>March 29, 1959</b><br>Death occurred at <b>7:40 A.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated. |   |   |   |
| 22a. SIGNATURE<br><b>L. Lachance, M.D.</b><br>(Degree or title)  |   | 22b. ADDRESS<br><b>Centralia, Missouri</b>  | 22c. DATE SIGNED<br><b>3-31-59</b>  |
| 23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify)<br><b>Burial</b>   | 23b. DATE<br><b>April 1-1959</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Zion</b>   | 23d. LOCATION (City, town, or county) (State)<br><b>south of Centralia, Mo.</b>                     |
| 24. FUNERAL DIRECTOR<br><b>Bill J. Meade Centralia, Missouri</b><br>ADDRESS  | 25. DATE RECD. BY LOCAL REG.<br><b>April 1-1959</b>   | 26. REGISTRAR'S SIGNATURE<br><b>Maud Mc Bride</b>   |   |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

APR 8 1956

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 *Bill J. Meadows* .....

Licensed Embalmer No. *4876* .....

P. O. Address *Centerville, Missouri* .....

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.