

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-020470  
STATE FILE NUMBER

FILED JUL 13 1959

Registration District No. 042

Primary Registration District No. 1000

Registrar's No. 688

S. 300  
1-57

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>DeKalb</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Nemphse</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Hillside N. Home</u> Length of stay in lb <u>13 days.</u>		d. STREET ADDRESS (If outside, give location) <u>632 e</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>-</u> Last <u>Fuchsinger</u>		4. DATE OF DEATH Month <u>7</u> Day <u>3</u> Year <u>1959</u>	
5. SEX <u>Male</u> COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-16-1881</u>	
9. AGE (In years last birthday) <u>78</u>		10. FUNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) <u>DeKalb Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>John F. Fuchsinger</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Bachmann</u>	
14. NAME OF HUSBAND OR WIFE <u>+ +</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>500-44-8737</u>	
17. INFORMANT <u>O.C. Fuchsinger, St. Joseph, Mo</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerosis Cerebral</u> DUE TO (c) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 months</u> <u>unknown</u>	
19. WAS AUTOPSY PERFORMED? <u>2</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
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.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK AT WORK		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>3/13/59</u> to <u>7/3/59</u> and last saw <u>him</u> alive on <u>7/1/59</u> Death occurred at <u>8:15 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Sharon E. Waggoner MD</u>		22b. ADDRESS <u>301 Illinois Ave</u> <u>St. Joseph, Missouri</u>	
22c. DATE SIGNED <u>7/3/59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>7-5-1959</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Independence Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>DeKalb Co. Mo.</u>	
24. FUNERAL DIRECTOR <u>W.E. Summerfield</u>		25. DATE RECD. BY LOCAL REG. <u>July 6, 1959</u>	
26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Goodell</u>			

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

Sharon E. Waggoner, MD  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

OCT 13 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 *N.E. Summerfield* .....

Licensed Embalmer No. *3007* .....

P. O. Address *Stuartsville, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.