

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

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Registrar's No. 1329

STATE FILE NUMBER

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| 1. PLACE OF DEATH a. COUNTY Buchanan | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph | | Length of stay in lb 2 years | | c. CITY OR TOWN St. Joseph | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Gen. Osteopathic Hospital | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 1029 Roosevelt Street | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First MIDDLE Last DORA FAUBION | | | | 4. DATE OF DEATH Month Day Year December 28 1959 | | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 8/27/1867 | 9. AGE (last birthday) 92 years | | IF UNDER 1 YEAR Months Days | IF UNDER 24 HR Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Seamstress | | | 10b. KIND OF BUSINESS OR INDUSTRY Department Store | | 11. BIRTHPLACE (City and state or country) Barton County, Mo. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME Marion L. Faubion | | | 13b. MOTHER'S MAIDEN NAME Nancy Broadhurst | | | 14. NAME OF HUSBAND OR WIFE None | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Rev. Russell Faubion, 1029 Roosevelt St., St. Joseph, Mo. | | | |
| 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 Hemorrhage</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | DUE TO (b) | | | | | DUE TO (c) | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | |
| 19. WAS AUTOPSY PERFORMED? 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 a.m. p.m. | | Month, Day, Year | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <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.) | | 20f. CITY, TOWN, OR LOCATION | | COUNTY | | STATE |
| 21. I attended the deceased from <u>12-27-59</u> to <u>12-29-59</u> and last saw her alive on <u>12-29-59</u> Death occurred at <u>8:25 P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (D.gree or title) <u>Dr. John Hartsock, D.O.</u> | | | | 22b. ADDRESS <u>1923 Buchanan</u> | | 22c. DATE SIGNED <u>12-29-59</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 12/31/1959 | 23c. NAME OF CEMETERY OR CREMATORY Highland Park Cemetery | | 23d. LOCATION (City, town, or county) Kansas City, Kansas | | | | |
| 24. FUNERAL DIRECTOR <u>James Funeral Home (B.A.S.)</u> | | | ADDRESS St. Joseph, Mo. | | 25. DATE RECD. BY LOCAL REG. <u>Dec. 31, 1959</u> | 26. REGISTRAR'S SIGNATURE <u>Mrs. Clerk Gordell</u> | | |

DOCUMENT

BY AFFIDAVIT OF J. Hartsock, D.O. DEED CERTIFICATION

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 Charles E. Bennett

Licensed Embalmer No. 4677

P. O. Address St. Joseph

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.