

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-033458

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 360 Primary Registration District No. 3076 Registrar's No. 147

FILED AUG 21 1962

VS 300 Rev. 4/59	DATE AMENDED
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1. PLACE OF DEATH a. COUNTY Vernon		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Vernon	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Nevada		Length of stay in lb 7 years	c. CITY OR TOWN Nevada Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Nevada Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1005 E. Berry Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WILLIAM Middle VINCENT Last FASKEN		4. DATE OF DEATH Month August Day 4 Year 1962	
5. SEX M	6. COLOR OR RACE Wh	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-15-1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Retired	9. AGE (last birthday) 74 IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HR: Hours <input type="checkbox"/> Min. <input type="checkbox"/>
11a. BIRTHPLACE (City and state or country) Jasper Co., Missouri		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME William Greeley Fasken		13b. MOTHER'S MAIDEN NAME Emma Bonds	14. NAME OF HUSBAND OR WIFE Anna Fasken
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. INFORMANT Anna Fasken Address Nevada, Missouri	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Cerebral arteriosclerosis 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			c. INTERVAL BETWEEN ONSET AND DEATH 9 days 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 April 1962 to Aug. 4, 1962 and last saw him alive on Aug. 3, 1962 Death occurred at Nevada, Mo. 12:20 A. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>L. P. McGann</i> L. P. McGann, M.D. (Degree or title)		22b. ADDRESS Moore Bldg., Nevada, Missouri	22c. DATE SIGNED 8/7/1962
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE August 6, 1962	23c. NAME OF CEMETERY OR CREMATORY Moore Cemetery	23d. LOCATION (City, town, or county) (State) Nevada Missouri
24. FUNERAL DIRECTOR Ferry Funeral Home ADDRESS Nevada, Missouri		25. DATE RECD. BY LOCAL REG. 8/21/62 26. REGISTRAR'S SIGNATURE <i>H. Starawala M.D.</i>	

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SHOULD READ

ITEM NO.

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

Ray E. Ireland

Licensed Embalmer No.

5052

P. O. Address

Newse No.

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.