

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-033782

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1088

FILED OCT 1 1962	
1. PLACE OF DEATH	
a. COUNTY Buchanan	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph,	a. STATE Missouri b. COUNTY Buchanan
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital #2	c. CITY OR TOWN Higginsville,
Length of stay in lb 1 Mo. 24 Days	d. STREET ADDRESS (If outside, give location) 5 Mi. North
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED	
First THEODORE	Middle FRED
Last FASSE	4. DATE OF DEATH
September 19 1962	
5. SEX Male	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 7/29/1875
9. AGE (last birthday) 87	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farm
11. BIRTHPLACE (City and state or country) Corder, Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Herman Fasse	13b. MOTHER'S MAIDEN NAME Elizabeth Schoppenhorst
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.	17. INFORMANT Miss Pauline Fasse-Higginsville, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:	
IMMEDIATE CAUSE (a) Cerebral Hemorrhage	
DUE TO (b) Generalized 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	
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 Sept 1962 to His death and last saw him alive on Sept. 19, 1962	
Death occurred at 4:15 PM m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) F. Thomas M.D.	22b. ADDRESS % State Hospital #2, St. Jos, Mo.
22c. DATE SIGNED 9/19/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9/21/1962
23c. NAME OF CEMETERY OR CREMATORY Evangelical Cemetery	23d. LOCATION (City, town, or county) (State) Higginsville, Missouri
24. FUNERAL DIRECTOR Meierhoffer-Fleeman Inc., St. Joseph, Mo.	25. DATE RECD. BY LOCAL REG. Sept. 28, 1962
26. REGISTRAR'S SIGNATURE Mrs. Clark Woodell	

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

DOCUMENT

BY AFFIDAVIT OF F. Thomas M.D. MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

VS 300 Rev. 4/59
15117
25710
3
4 0
5 0
6
7 0
8 2
9 331X
10
11
12 93.0
13 1-0

Permit issued 9/19/62

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 Raymond A. Hoop

Licensed Embalmer No. 5147

P. O. Address St Joseph, 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.