

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31647
Registrar's No. 88

Registration District No. 35

Primary Registration District No. 3010

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1. PLACE OF DEATH:
(a) County Carroll
(b) City or town Carrollton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
South Side (Benson) Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day (Specify whether years, months or days)

8. (a) PRINT FULL NAME Richard B. Fanning
8. (b) If veteran, name war _____ 8. (c) Social Security No. 486-09-9519

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Agnes Fanning 6. (c) Age of husband or wife if alive 29 years
7. Birth date of deceased February 23 1915
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
25 7 2 hr. min.

9. Birthplace Chula Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Clerk

11. Industry or business _____
12. Name William B. Fanning
13. Birthplace Tindel Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Geneve May
15. Birthplace Chula Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature William B. Fanning
(b) Address Omaha, Nebraska

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-27-'40
(Month) (Day) (Year)

(c) Place: burial or cremation May Cemetery.
18. (a) Signature of funeral director F. B. Norman Co.
(b) Address Chillicothe, Missouri

19. (a) 9-26-1940 (Date received local registrar) (b) Spith Nebraska (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL.")
(d) Street No. 2900 Park (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept 25 day _____ year 1940 hour 8 minute 30 P. M.
21. I hereby certify that I attended the deceased from Sept 28 to Sept 28-40, 19____; that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____
Due to Concussion from Continuous Accident
Due to _____
Other conditions (include pregnancy within 3 months of death) _____

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident
(b) Date of occurrence 9-25-1940 4:45 AM.
(c) Where did injury occur? Waverly, Lafayette Mo.
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
on State Highway #24
While at work no. (Specify type of place) (e) Means of injury auto
23. Signature W. W. Waverly (M. D. or other) Address Carrollton, Mo. Date signed 9-26-40

210M
11

RECEIVED
District Health Officer No. 8,
District File Number
10-4-40
Date Filed

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.....

Elton E. Norman & E. R. Norman (2374)....., Registered Apprentice No.....
working under my personal supervision.

Signed Elton E. Norman.....

Licensed Embalmer No. 4036.....

P. O. Address Chillicothe, 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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. **31647**
Registrar's No. **88**

Registration District No. **135-**

Primary Registration District No. **3010**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
 (a) County **Carrollton**
 (b) City or town **Carrollton**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether)
 In this community _____
years, months or days

3. (a) PRINT FULL NAME **Richard B. Fanning**
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex **m** **5. Color or race** **w**
6. (a) Single, widowed, married, divorced **m**
6. (b) Name of husband or wife _____
6. (c) Age of husband, or wife, if alive _____ years
7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
25	7	2	_____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name _____
13. Birthplace _____
(City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ **(b) Date thereof** _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ **(b)** _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State _____ (b) County _____
 (c) City or town _____
(If outside city or town limits write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

20. DATE OF DEATH **Sept 25-**
 _____ month _____ day _____
 _____ year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw him _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death **Concussion of Brain**
automobile accident

Due to **Two Autos collided**

Other conditions **Arteriosclerosis**
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

PHYSICIAN

 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **acc.**

(b) Date of occurrence **9-25-1940**

(c) Where did injury occur? **Waverly mo.**
(City or town) (County) (State)

(d) Did injury occur on or about home, on farm, in industrial place, in public place?
Highway #24
(Specify type of place)
 While at work _____ (e) Means of injury _____

23. Signature **R. W. Keen** (M. D. or other) _____
Address **Rowley 40**

SUPPLEMENTARY

