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FILED JAN 8 1941

Registrar's No. **4617**

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(c) Name of hospital or institution St Lukes Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 hrs  
In this community 2 years  
years, months or days

3. (a) PRINT FULL NAME James George Fauble

3. (b) If veteran, name war no 3. (c) Social Security No. 720

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife 2 6. (c) Age of husband or wife if alive 3 years

7. Birth date of deceased 7/3 (Month) 1938 (Day) (Year)

8. AGE: Years 2 Months 1 Days 0 If less than one day hr. min.

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

10. Usual occupation child

11. Industry or business

12. Name Eugene Fauble

13. Birthplace Nebraska (City, town, or county) (State or foreign country)

14. Maiden name Eva Loshaupt

15. Birthplace Nebraska (City, town, or county) (State or foreign country)

16. (a) Informant Eugene Fauble

(b) Address 4434 - Washington

17. (a) Removal (b) Date thereof 12-4-40 (Month) (Day) (Year)

(c) Place: burial or cremation Columbus, Neb.

18. (a) Signature of funeral director Benjamin Eugene Lane

(b) Address 4306 - Mid Creek Pky.

19. (a) 12-4-40 (Date received local registrar) (b) M. M. Brown (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. 4434 Washington  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 3 year 1940 hour \_\_\_\_\_ minute 10 M.

21. I hereby certify that I attended the deceased from Dec 3 1940 to Dec 3 1940 that I last saw h. alive on Dec 3 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Acute pharyngitis - tracheitis Duration 7 hrs

Due to strep. throat

Due to 1060

Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations

autopsy Acute tracheitis & laryngitis - cultures etc.

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

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

(Specify type of place) (Specify type of place) While at work? (b) Means of injury

23. Signature E. W. H. H. H. H. H. (M. D. or other)

Address Ray, Mo. Date signed 12-4-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

**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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*Harry Bergman*

Licensed Embalmer No.....

*204*

P. O. Address.....

*Kan City, 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, fact should be so stated above.**