

FILED FEB 6 1945
749
Registration District No. _____

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:
 (a) County KANSAS
 (b) City or town KANSAS CITY
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
824 WEST 71ST STREET TERRACE
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether)
 In this community 42 YEARS /
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State MISSOURI (b) County JACKSON
 (c) City or town KANSAS CITY 4th
(If outside city or town limits, write "RURAL")
 (d) Street No. 824 WEST 71ST STREET TERRACE
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME MR. WILLIAM NELSON FAUST
 3. (b) If veteran, name war No
 3. (c) Social Security No. 486-05-6569

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month JAN day 22ND
 year 1945 hour 8 minute 45 A.M.
 21. I hereby certify that I attended the deceased from
Dec 14 1944 to Jan 22 1945
 that I last saw him alive on Jan 3 1945
 and that death occurred on the date and hour stated above.

4. Sex MALE 5. Color or race WHITE
 6. (a) Single, widowed, married, divorced MARRIED
 6. (b) Name of husband or wife MRS. MARGARET FAUST
 6. (c) Age of husband or wife if alive 61 years
 7. Birth date of deceased NOVEMBER 9 - 1873
(Month) (Day) (Year)

Immediate cause of death Broncho-pneumonia
Carcinoma lung
 Duration 3-4
8-mo

8. AGE:

Years	Months	Days	If less than one day
<u>71</u>	<u>2</u>	<u>13</u>	hr. _____ min. _____

Due to _____
 Due to _____
 Other conditions _____
(Include pregnancy, within 3 months of death)
 Major findings:
 Of operations _____
 Of autopsy _____

9. Birthplace MANSFIELD OHIO
(City, town, or county) (State or foreign country)
 10. Usual occupation RETIRED - 2 YEARS - DIV. PLANT SUP.
 11. Industry or business SOUTHWESTERN BELL TEL. Co.
MOTHER FATHER
 12. Name LOUIS WILLIAM FAUST
 13. Birthplace Ohio
(City, town, or county) (State or foreign country)
 14. Maiden name AMANDA GRIBLING
 15. Birthplace Ohio
(City, town, or county) (State or foreign country)
 16. (a) Informant MRS. MARGARET FAUST
 (b) Address 824 WEST 71ST STREET TERRACE
 17. (a) CREMATION (b) Date thereof JAN 24 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation DW. NEWCOMER'S JONS
 18. (a) Signature of funeral director D. H. Newcomer's Sons
 (b) Address 1401 BRUSH GREEN BLVD.
 19. (a) 1-23-45 (b) P. E. Brown
(Date received local registrar) (Registrar's signature)

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)
 While at work? _____ (e) Means of injury _____
 23. Signature J. B. Wallace (M. D. brother)
 Address 703 KATHAR BLVD Date signed 1-23-45

PHYSICIAN
 Underline the cause to which death should be charged statistically.

Dr. J. H. [redacted] D. Wallace [redacted]
703 Kellway Bldg. 10th & Grand
1-6:30

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 Emile M. Calhoun
Licensed Embalmer No. 3506
P. O. Address K C 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.