

S. No. 2
M-5-43
5-17-39
X36671

State File No.

Registrar's No. 175

FILED JAN 31 1946
Registration District No. 177

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kennett City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 3537 Main St 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 days
(Specify whether)

In this community 3 yrs
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kennett City
(If outside city or town limits, write "RURAL")

(d) Street No. 3118 Agnes
(If rural, give location)

(e) Citizen of foreign country? Yes
If yes, name country _____

3. (a) PRINT FULL NAME Elizabeth Fasing

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife W. H. Fasing

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct 27 1962
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>83</u>	<u>2</u>	<u>14</u>	hr. min.

9. Birthplace Ithaca Ohio 1
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business John Fasing

12. Name John Fasing

13. Birthplace Germany Ohio 4
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Covell

15. Birthplace Germany Ohio 4
(City, town, or county) (State or foreign country)

16. (a) Informant Russell Fasing

(b) Address 1320 R.A. Long Bldg

17. (a) Removal (b) Date thereof Jan 12-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Arcaunum Ohio

18. (a) Signature of funeral director Mr. E. R. Foster

(b) Address 918 Broadway K.C. Mo

19. (a) 1-12-46 (b) Dr. Erling Holmedal
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 11
year 1946 hour 2 minute 35

21. I hereby certify that I attended the deceased from Jan 11 1946
to Jan 11 1946

that I last saw h. _____ alive on _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Labor Pneumonia

Due to septicemia

Due to Altered valves (Central)

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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? _____

While at work? _____ (Specify type of place)

(c) Means of injury _____

23. Signature [Signature] (M. D. or other)

Address 101 1/2 W. 12th St Date signed Jan 12-46

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Dr. H.C. Trappe
agrile Bldg
HA - 3454

John etc

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.....

Joe B. Yoder

Licensed Embalmer No. *4173*

P. O. Address *KC. 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.