

DEPARTMENT OF COMMERCE THE STATE BOARD OF HEALTH OF MISSOURI
BUREAU OF THE CENSUS STANDARD CERTIFICATE OF DEATH

FILED FEB 28 1946

State File No. 4936

Registration District No. 78 Primary Registration District No. 5281 Registrar's No. 4

1. PLACE OF DEATH:
(a) County Clark
(b) City or town Lathrop
(c) Name of hospital or institution Clark Co. Home
(d) Length of stay: In hospital or institution 2 weeks
In this community life

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Clark
(c) City or town Wayland Mo.
(d) Street No. 23
(e) Citizen of foreign country? No

3. (a) PRINT FULL NAME Cynthia Faekler
3. (b) If veteran, name war. No.
3. (c) Social Security No.
4. Sex female
5. Color or race white
6. (a) Single, widowed, married, divorced, widowed
6. (b) Name of husband or wife James Faekler
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Dec 15 - 1865

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Dec day 27
year 1945 hour 3 minute P.M.
21. I hereby certify that I attended the deceased from 12/27/45 to 12/27/45
that I last saw h. alive on 12/27/45
and that death occurred on the date and hour stated above.

8. AGE: Years 70 Months 12 Days hr. min.
9. Birthplace Mo. (State or foreign country)

Immediate cause of death: Cerebral Hemorrhage
Due to...
Due to...
Other conditions: (Include pregnancy within 3 months of death)

11. Industry or business
12. Name Mrs. Beall
13. Birthplace Pa. (State or foreign country)
14. Maiden name Melvina Hight
15. Birthplace Ky. (State or foreign country)
16. (a) Informant Mrs. Dorothy Daniels
(b) Address Coffey Kan.
17. (a) Burial (b) Date thereof Dec 30 - 1945
(c) Place: burial or cremation Fraser Co. Wayland Mo.
18. (a) Signature of funeral director [Signature]
(b) Address Lathrop Mo.
19. (a) 1-15-46 (Date received local registrar) [Signature] (Registrar's signature)

Major findings: Of operations [Signature]
Of autopsy [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?
While at work (Specify type of place) (e) Means of injury
23. Signature [Signature] (M. D. or other)
Address [Signature] Date signed

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

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
100978

RECEIVED

District Health Officer No. 10

District File Number 2-46-242

Date Filed FEB 25 1946

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 W. L. Sutter

Licensed Embalmer No. 29650

P. O. Address Peasano

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.