

S. No. 2
M-5-43
7. 5-17-39
D I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
U. S. GOVERNMENT PRINTING OFFICE: 1934
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6497**
Registrar's No. **13**

Registration District No. **217** Primary Registration District No. **3045**

67
1
2
5456
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County **Mississippi**
(b) City or town **Charleston**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
310 West Commercial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community **66 Years** years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Mississippi**
(c) City or town **Charleston**
(d) Street No. **310 West Commercial**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **None**

3. (a) PRINT FULL NAME **Sophia Marie Faust**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **January** day **1st**
year **1946** hour **10** minute **15** A.M.

4. Sex **F** 5. Color or race **White**
6. (a) Single, widowed, married, divorced, **Widowed**
6. (b) Name of husband or wife **George Faust** (d) alive _____ years
7. Birth date of deceased **November 6th 1863**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **1943**, 19____, to **Jan 1**, 19**46**
that I last saw **ER** alive on **Dec 31**, 19**45**
and that death occurred on the date and hour stated above.

8. AGE: Years **82** Months **1** Days **25**
If less than one day hr. _____ min. _____

Immediate cause of death
Ventricular Fibril 3 wks
Due to **Myocardites**
Due to **Coronary Disease**
Other conditions **Arteriosclerosis**
(Include pregnancy within 3 months of death)

9. Birthplace **Lanes Valley Ohio**
(City, town, or county) (State or foreign country)
10. Usual occupation **Housewife**

11. Industry or business _____
12. Name **Christine Vogley**
13. Birthplace **Switzerland**
14. Maiden name **Susana Niedringhauser**
15. Birthplace **Switzerland**

PHYSICIAN
Major findings:
Of operations _____
Of autopsy **940**
Underline the cause to which death should be charged statistically.

16. (a) Informant **Mrs. Cora Randall**
(b) Address **Charleston, Mo.**
17. (a) **Burial** (b) Date thereof **1-3-46**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Oak Grove, Charleston**

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? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **Mo.**

18. (a) Signature of funeral director **[Signature]**
(b) Address **Charleston, Mo.**
19. (a) **2-5-46** (b) **Mrs. John Bondurant**
(Date received local registrar) (Registrar's signature)

23. Signature **[Signature]** (M. D. or other)
Address **Charleston, Mo.** Date signed **1/6/46**

RECEIVED

District Health Office No. 2,

District File Number 346-295

Date Filed 3-4-46

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 John F. Hummel Jr

Licensed Embalmer No. 3851

P. O. Address Charleston, 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.