

No. 2  
-12-45  
5-17-39  
X47370

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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED APR 23 1947**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

13436

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

Registrar's No. 1652

**1. PLACE OF DEATH:**  
 (a) County Jackson  
 (b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
512 Woodland 4 conv. Home  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 1 Year  
(Specify whether years, months or days)  
 In this community 20 Years

**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. 512 Woodland  
(If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Charles Cassus Faunce  
 3. (b) If veteran, name war no  
 3. (c) Social Security No. None

4. Sex Male 5. Color or race White  
 6. (a) Single, widowed, married, divorced Widowed  
 6. (b) Name of husband or wife Jeannette Faunce  
 6. (c) Age of husband or wife if alive years  
 7. Birth date of deceased Oct-16-1864  
(Month) (Day) (Year)

**8. AGE:**  
 Years 82 Months 5 Days 24  
 If less than one day hr min.

9. Birthplace Effingham Ill  
(City, town, or county) (State or foreign country)

10. Usual occupation Performer

11. Industry or business Dances

12. Name H. D. Faunce

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

14. Maiden name Mariah Rechner

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

16. (a) Informant Chas. C. Faunce

(b) Address 512 Woodland

17. (a) Burial (b) Date thereof ap 12 47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Wm C R Foster

(b) Address 918 Broadway

19. (a) 4-11-47 (b) Shirley Holmes  
(Date received local registrar) (Registrar's signature)

MOTHER FATHER

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month April day 10th.  
 year 1947 hour 10 minute A.

21. I hereby certify that I attended the deceased from April 7  
1947 to April 10, 1947  
 that I last saw him alive on April 10, 1947  
 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia  
 Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Anterior scleritis  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations \_\_\_\_\_

Of autopsy 108

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

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 C. P. Rector, M.D. (M. D. or other) \_\_\_\_\_

Address 720 G. Street Date signed 4-10-47

**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..... *Cortland J. Miss*

Licensed Embalmer No. *3414*

P. O. Address *918 Brooklyn*

**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.**