V. S. No. 2
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Rev. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 7 1947

Registration District No. 746

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3026

State File No. 34752

Registrar's No. 316

1. PLACE OF DEATH:

(a) County Jackson.

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

(c) Name of hospital or institution: Independence Sanitorium O
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Day (Specify whether years, months or days)

In this community 1 Day

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town K. C. 3
(If outside city or town limits, write "RURAL")

(d) Street No. 11798 Indep. Ave. X
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 1

If yes, name country —

3. (a) PRINT FULL NAME Baby Fahrion

3. (b) If veteran, name war —

3. (c) Social Security No. None

4. Sex Male O

5. Color or race White

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

6. (b) Name of husband or wife —

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

7. Birth date of deceased Oct (Month) 19 (Day) - 1947 (Year)

8. AGE: Years 0 Months 0 Days 1 If less than one day ___ hr. ___ min.

9. Birthplace Independence (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Child

11. Industry or business

FATHER
12. Name Alfred P. Fahrion
13. Birthplace St. Paul, (City, town, or county) Minnesota (State or foreign country)

MOTHER
14. Maiden name Harriet Collins
15. Birthplace Minn. (City, town, or county) (State or foreign country)

16. (a) Informant Alfred P. Fahrion
(b) Address 11798 Indep. Ave K.C. Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 21 1947 (Month) (Day) (Year)
(c) Place: burial or cremation Mt. St. Mary K.C. Mo

18. (a) Signature of funeral director Dolan L. Copley
(b) Address Independence, Mo.

19. (a) 10-22-47 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 20 TS year 1947 hour 7 minute 50 P. M.

21. I hereby certify that I attended the deceased from Oct. 19, 1947, to Oct. 20, 1947; that I last saw him alive on Oct 20, 1947; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Generalized Atelectasis	
Due to: Prematurity + Prolapsed umbilical cord	
Due to:	
Other conditions: — (Include pregnancy within 3 months of death)	
Major findings: Of operations: None done	
Of autopsy: None done	

16 OC

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?

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (City or town) (County) (State)

While at work? (Specify type of place) (e) Means of injury O

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

Address Independence Mo Date signed Oct 21 1947

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was NOT embalmed ~~by me~~, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

NOT EMBALMED

Signed. Dixon L. Kepler

Licensed Embalmer No. X 4225

P. O. Address. Indep. 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.