

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

34190

State File No.

No. 300
10. 48

0105
0

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

FILED OCT 27 1952

BIRTH NO. _____		REG. DIST. NO. <u>38</u>		PRIMARY REG. DIST. NO. <u>3006</u>		Registrar's No. <u>284</u>	
1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Columbia</u>			c. LENGTH OF STAY (In this place) <u>88 yrs</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>Columbia</u>			d. STREET ADDRESS (If rural, give location) <u>208 Lyons St</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Boone Co Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>208 Lyons St</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>James</u> b. (Middle) <u>D</u> c. (Last) <u>Fay</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 18th 1952</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>April 20 1852</u>		9. AGE (In years last birthday) <u>100</u>	IF UNDER 1 YEAR Month <u>6</u> Day <u>3</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bricklayer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Brickmason</u>		11. BIRTHPLACE (City or State or Foreign Country) <u>Newburg Orange Co N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James D Fay</u>		13b. MOTHER'S MAIDEN NAME <u>Mariam Trumper</u>		14. NAME OF HUSBAND OR WIFE <u>Henrietta Wings Fay</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT'S SIGNATURE OR NAME & ADDRESS <u>James D Fay Pre Arranged</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		<p align="center">MEDICAL CERTIFICATION</p> I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>PNEUMONIA - BILATERAL</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>ARTERIO-SCLEROTIC HEART DISEASE</u> DUE TO (c) <u>FRACTURE OF RT HIP</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Old Age</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 Wk.</u> <u>VENGE.</u> <u>3 Wks</u> <u>E9035</u> <u>44</u>	
19a. DATE OF OPERATION <u>9/26/52</u>		19b. MAJOR FINDINGS OF OPERATION <u>FRACTURE (INTER TROCHANTERIC TYPE) RT HIP</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT (Specify) <u>HOME</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>STREETS</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>COLUMBIA BOONE MO.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>9-24-52</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR <u>FALL WHILE CROSSING STREET</u>			
22. I hereby certify that I attended the deceased from <u>9/24, 1952</u> to <u>10/18, 1952</u> , that I last saw the deceased alive on <u>10/18, 1952</u> , and that death occurred at <u>1:45 P.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>John M. Gray M.D.</u>				23b. ADDRESS <u>Columbia Mo</u>		23c. DATE SIGNED <u>10/20/52</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Oct 21 52</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Columbia Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Columbia Mo</u>		
DATE REC'D BY LOCAL REG. <u>Oct 20, 1952</u>		REGISTRAR'S SIGNATURE <u>Mrs R.E. Palmer</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. O. Wilson</u>		ADDRESS <u>Columbia Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

DEC 23 1954

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, ~~and~~ _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Lyman H. Sprinkle

Licensed Embalmer No. 4013

P. O. Address Columbia, 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.