

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED FEB 8 1954 REG. DIST. NO. 15 PRIMARY REG. DIST. NO. 5020 Registrar's No. 8

1. PLACE OF DEATH a. COUNTY Barton		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Barton	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Milford	c. LENGTH OF STAY (In this place) 75 yrs	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Milford	
d. FULL NAME OF HOSPITAL OR INSTITUTION None		d. STREET ADDRESS (If rural, give location) 0060 0	

3. NAME OF DECEASED (Type or Print) a. (First) NETTIE b. (Middle) SCOTT c. (Last) FAUBION	4. DATE OF DEATH (Month) (Day) (Year) 1 27 54							
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Feb. 2, 1868	9. AGE (In years last birthday) 86	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? US				

13a. FATHER'S NAME Will Scott	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Clarence Faubion
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Ora Faubion Milford Mo.

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH 3 mo 6 y
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Atherosclerosis		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 4201	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 12, 1953, to 1-27, 1954, that I last saw the deceased alive on 1-27, 1954, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) S. B. Bamister M.D.	23b. ADDRESS Sheldon Mo.	23c. DATE SIGNED 1-28-54
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Jan. 29, 1954	24c. NAME OF CEMETERY OR CREMATORY Howell
24d. LOCATION (City, town, or county) (State) Milford Mo.		

DATE REC'D BY LOCAL REG. FEB 3 - 1954	REGISTRAR'S SIGNATURE Marie Konantz	25. FUNERAL DIRECTOR'S SIGNATURE L. Gerald Deery	ADDRESS Sheldon Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

.....  
working under my personal supervision.

Student Embalmer No. ....

Signed.....

*Gerald Berry*

Signed.....

Student Embalmer

Licensed Embalmer No. *1323*

P. O. Address *Bellevue, 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.