

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-005076
STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 216

AMENDED

FILED VS MAR 6 1961

DATE AMENDED

INSTEAD OF THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Greene</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u> | | c. CITY OR TOWN <u>Springfield</u> | |
| Length of stay in 1b | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Doctors' Memorial Osteopathic</u> | | d. STREET ADDRESS (If outside, give location) <u>1036 West Atlantic</u> | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Della Ann Faubion</u> | | | 4. DATE OF DEATH Month Day Year <u>February 26, 1961</u> |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>1/20/1883</u> |
| 9. AGE (last birthday) <u>78</u> | | IF UNDER 1 YEAR Months Days | IF UNDER 24 HR Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <u>Springfield, Missouri</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u> | | 13a. FATHER'S NAME <u>Joseph McKee</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>Lucindy Sneed</u> | | 14. NAME OF HUSBAND OR WIFE <u>N. Arthur Faubion</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>491-03-6004-B</u> | 17. INFORMANT Address <u>N. Arthur Faubion 1036 W. Atlantic Spfld</u> |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Medullary Failure</u> | | | <u>9 hours</u> |
| DUE TO (b) <u>Thrombotic Encephalomalacia & Diabetes Mellitus</u> | | | <u>14 days</u> |
| DUE TO (c) <u>Arteriosclerosis</u> | | | <u>approximate 25 year per</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour Month, Day, Year p.m. | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION | COUNTY STATE |
| 21. I attended the deceased from <u>February 12, 1961</u> to <u>February 26, 1961</u> and last saw her/him alive on <u>February 26, 1961</u> . Death occurred at <u>12:00</u> P.m. on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>E. L. Williams D.O.</u> | | 22b. ADDRESS <u>Landers Building Springfield</u> | 22c. DATE SIGNED <u>2-26-61</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>2-26-61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Robberson Prairie</u> | 23d. LOCATION (City, town, or county) (State) <u>Greene County Missouri</u> |
| 24. FUNERAL DIRECTOR <u>Klingner Mortuary Inc., 1635 N. Benton</u> | | 25. DATE RECD. BY LOCAL REG. <u>2-28-61</u> | 26. REGISTRAR'S SIGNATURE <u>Effie E. Melton</u> |

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 _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Ogle Stone Jr.

Licensed Embalmer No. 4176

P. O. Address Springfield

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.