

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-017672

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 325 Primary Registration District No. 4472 Registrar's No. 59

FILED APR 30 1962

VS 300
Rev. 4/59

10980
20980-

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4 0
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932XH
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Schuyler</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Schuyler</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Glenwood Mo</u>		c. CITY OR TOWN <u>Glenwood Mo</u>	
Length of stay in 1b <u>58yr</u>		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>Home</u>		d. STREET ADDRESS (If outside, give location) <u>Home</u>	
3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle <u>Grant</u> Last <u>Faist</u>		4. DATE OF DEATH Month <u>Apr</u> Day <u>22</u> Year <u>62</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</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>Jan 28 1883</u>
9. AGE (last birthday) <u>79</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>24</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Painter</u>	
11. BIRTHPLACE (City and state or country) <u>Monterey Iowa</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13a. FATHER'S NAME <u>Mathias Faist</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Gee</u>	
14. NAME OF HUSBAND OR WIFE <u>Martha Faist</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Martha Faist</u>		Address <u>Glenwood Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Medullary failure</u> DUE TO (b) <u>Central thrombosis</u> DUE TO (c) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic lymphocytic leukemia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>years</u>
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 <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u></u>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>10-16-53</u> to <u>4-22-62</u> and last saw him alive on <u>4-20-62</u> Death occurred at <u>4:40</u> <u>A.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>NP Stoker</u>		22b. ADDRESS <u>Lancaster, Mo.</u>	
22c. DATE SIGNED <u>4-23-62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Apr 24 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F.</u>		23d. LOCATION (City, town, or county) <u>Glenwood Mo</u>	
24. FUNERAL DIRECTOR <u>Normans</u>		ADDRESS <u>Lancaster Mo</u>	
25. DATE RECD. BY LOCAL REG. <u>April 23, 1962</u>		26. REGISTRAR'S SIGNATURE <u>Florence Shepherd</u>	

MAY 17 1962

Permit Obtained April 23-1962

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

David E. Foster

Licensed Embalmer No.

4742

P. O. Address

Kirksville, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

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