

COMMONWEALTH OF KENTUCKY
State Board of Health
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Dr. Stone

1 **PLACE OF DEATH**
County Christian

File No. _____

Vet. Pct. City

Registration District No. 350

Registered No. 24425/1

Inc. Town _____

Primary Registration District No. 2115

City _____ (No. _____ St., _____ Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME M. M. Faugender

(a) Residence. No. _____ St., _____ Ward. _____
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single Single
Married Single
Widowed Single
or Divorced Single
(Write the word)

5a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

6 DATE OF BIRTH Dec. 2 86
(Month) (Day) (Year)

7 AGE 4 yrs. _____ mos. _____ ds.
IF LESS than 1 day _____ hrs. or _____ min?

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School teacher
(b) General nature of industry, business or establishment in which employed (or employer) _____

9 BIRTHPLACE (city or town) Ky
(State or country)

PARENTS
10 NAME OF FATHER W. G. Faugender
11 BIRTHPLACE OF FATHER (city or town) Ky
(State or country)
12 MAIDEN NAME OF MOTHER Christy Rice
13 BIRTHPLACE OF MOTHER (city or town) Ky
(State or country)

14 (Informant) E. Faugender
(Address) Kirkmansville

15 Filed Oct. 30 1928 Quincy Bagley
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 10 30 28
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 30 1928 to Oct 30 1928 that I last saw him alive on Oct 20 1928 and that death occurred on the date stated above at 8 a. m.
The CAUSE OF DEATH* was as follows:
Embolic Cordia
from tumor of kidney

(Duration) 3 yrs. _____ mos. _____ ds.
Contributory _____
(Secondary) _____
(Duration) _____ yrs. _____ mos. _____ ds.

18 WHERE WAS DISEASE CONTRACTED
If not at place of death? Not known
Did an operation precede death? No Date of _____
Was there an autopsy? No
What test confirmed diagnosis? Chemical
(Signed) Dr. Stone M. D.
10-30-1928 (Address) Hopkinsville

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means and nature of Injury; and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL OR REMOVAL Mableton Ky DATE OF BURIAL 10-31 1928
near Hopkinsville
20 UNDERTAKER Waller and Harton ADDRESS Hopkinsville

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WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.