

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

APR 26 1935

10384

188

1. PLACE OF DEATH

County St. Francois Registration District No. 772 File No. 188
Township St. Francois Primary Registration District No. 4463 Registered No. _____
City Elm (No. 60183 St. _____ Ward) _____

2. FULL NAME

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Nancy Faulkner

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 1st 1865

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
70 2 29

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Washington
(STATE OR COUNTRY) Mo

10. NAME OF FATHER Wm Faulkner

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ohio
(STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER Ann Elders

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ohio
(STATE OR COUNTRY) _____

14. INFORMANT A. B. Lupkey
(Address) Elm Mo.

15. H. B. 19 35 C. B. Starr
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 31, 1935

17. I HEREBY CERTIFY, That I attended deceased from March 3rd, 1935, to March 31st, 1935, that I last saw him/her alive on March 19th, 1935, and that death occurred, on the date stated above, at 9:30 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

myocarditis
arterio-sclerosis
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) gout

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? exam.

(Signed) J. A. Melham, M.D. M.D.
, 19 (Address) Blair River, Mo.

*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, CREMATION, OR REMOVAL parkview DATE OF BURIAL 4-2 1935
Cemetery

20. UNDERTAKER Caldwell Bros ADDRESS Blair River

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.

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BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....
 Township..... Primary Registration District No..... Registered No.....
 City..... (No.....) St..... Ward.....

2. FULL NAME

(a) Residence. No..... St..... Ward.....
 (Usual place of abode)
 Length of residence in city or town where death occurred..... yrs. mos. da. How long in U.S., if of foreign birth?..... yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX..... 4. COLOR OR RACE..... 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day,..... hrs. or..... min.

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work.....
 (b) General nature of industry, business, or establishment in which employed (or employer).....
 (c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14. INFORMANT (Address)

15. FILED..... 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19.....

17. I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19....., that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

(duration)..... yrs. mos. da.

(duration)..... yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed).....

, 19 (Address)

M. D

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19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS