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.

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

PLACE OF DEATH

County Knox

Township or Village or City Bourbon Novelty

Registration District No. 447 File No. 40513

Primary Registration District No. 5607 Registered No. 7

(NO. ..... St.: ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Carmelian Falkenstein

PERSONAL AND STATISTICAL PARTICULARS

SEX Male ~~Female~~ COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widow

DATE OF BIRTH February 25 (Month) (Day) 1834 (Year)

AGE 84 yrs. 8 mos. 12 ds. If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Brown Co Penna.

PARENTS
NAME OF FATHER Samuel Falkenstein
BIRTHPLACE OF FATHER (City or town, State or foreign country) Penna.
MAIDEN NAME OF MOTHER Solome ~~Sneidings~~ Reidings
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Penna

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mariam Falkenstein

(ADDRESS) Novelty Mo.

Filed Nov 8 1918 Frank Baldwin REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH November (Month) 7 (Day), 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from July, 1918, to Nov. 7, 1918, that I last saw h..... alive on Nov. 5, 1918, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

~~Cardiac Insufficiency~~

Cardiac Insufficiency

950

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (SECONDARY) Dropsical effusion

(Duration) 5 or 6 yrs. ..... mos. ..... ds.

(Signed) W. W. Owen M. D.

..... 191.... (Address) Novelty Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL Novelty

DATE OF BURIAL Nov 8 1918

UNDERTAKER J W Hudson

ADDRESS Novelty Mo

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

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....

or

Village..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. ....., ... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write the word*)

DATE OF BIRTH

....., *1*..... (Month) (Day) (Year)

AGE ..... yrs. ..... mos. ..... ds. | If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191....., ... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., *191*..... (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....,

that I last saw h..... alive on ....., 191.....,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory ..... (SECONDARY)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

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

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
UNDERTAKER	ADDRESS

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 import