

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

Do not use this space.

29260

1. PLACE OF DEATH

County..... Registration District No.....
Township..... Primary Registration District No.....
City *St. Louis mo.* (No. *Josephine Hospital*)

File No.....
Registered No. *8397*
St. Ward)

2. FULL NAME

Carrie A Faulkner

(a) Residence. No. *903 Park ave* St., *23* Ward.

(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 *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) *Widowed*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *July 4-1866*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
63 1 11

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *Housewife*
(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) *Missouri*

10. NAME OF FATHER *Nathan Thurman*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Missouri*

12. MAIDEN NAME OF MOTHER *Lucy Pinkston*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Missouri*

14. INFORMANT *Virginia Zachritz*
(Address) *716 Mason*

15. FILED *2111 C. Staritz* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Aug 15 1929*

17. I HEREBY CERTIFY, That I attended deceased *Aug 12th* 19*29*, to *Aug 15th* 19*29*, that I last saw h. ex. alive on *Aug 15th* 19*29*, and that death occurred, on the date stated above, at *1:01* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Myocarditis

5 (duration) yrs. mos. *2* ds.
CONTRIBUTORY (SECONDARY) *Gastroenteritis*
5 (duration) yrs. mos. *5* ds.

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? *Robert Bender M. D.*
(Signed) *Aug 12th 1929* (Address) *1012 Seyer av*

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
Valhalla Cemetery 8-17-29

20. UNDERTAKER ADDRESS
McLaughlin 1631 mo. ave

WRITE PLAINLY, WITH UNFAADING INK---THIS IS AN 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.

