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

Do not use this space.

6188-3

6188-2

1. PLACE OF DEATH
County: Lewis
Township: Lewis
City: Maywood (No. ..... St. ..... Ward)
Registration District No. 480
Primary Registration District No. 5645
File No. .....
Registered No. 3

2. FULL NAME: James E. Faulconer

(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.

MAY 25 1931

PERSONAL AND STATISTICAL PARTICULARS

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

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF —

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Jan 13 1907

7. AGE: Years 24 | Months 1 | Days 28 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Labor
(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): Maywood Mo

PARENTS
10. NAME OF FATHER: Spencer Faulconer
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Lewis Co Mo
12. MAIDEN NAME OF MOTHER: Anna M. Hull
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Canton Mo

14. INFORMANT: Spencer Faulconer
(Address): Maywood Mo

15. FILED 2/19 1931 W B Ellery REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Feb 11 1931

17. I HEREBY CERTIFY, That I attended deceased from Feb 2nd 1931, to Feb 11th 1931, that I last saw him alive on Feb 11th 1931, and that death occurred, on the date stated above, at 10.30 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Diabetes Mellitus
59
(duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Coma cause from Diabetes
(duration) ..... yrs. ..... mos. 1 ds.

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? Laboratory
(Signed) Dr. L. E. Carr, M.D.
, 19 (Address) La Grange 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Maywood Mo
DATE OF BURIAL: Feb 13 1931

20. UNDERTAKER: J H Chambers
ADDRESS: Maywood Mo

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.