

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

Do not use this space.

36323

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1932

1. PLACE OF DEATH

County *St. Louis*
Township
City *Marshall* (No. _____) St. _____ Ward _____

Registration District No. *502*
Primary Registration District No. *4305*

File No. _____
Registered No. *37*

2. FULL NAME

Margaret Jane Faulkner

(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 *44* 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** *widowed*
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Sept 28 1888*

7. AGE YEARS *74* MONTHS *2* DAYS *1* If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *at Home*
10. Date deceased last worked at this occupation (month and year) _____ **11. Total time (years) spent in this occupation** _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *New Boston Mo*

13. NAME *Wm Gorton*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ky*

15. MAIDEN NAME *Eveline*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ind*

17. INFORMANT (ADDRESS) *Mrs Ed Hittick Marshall Mo*

18. BURIAL, CREMATION, OR REMOVAL
PLACE *St. Charles* DATE *Dec 11 1932*

19. UNDERTAKER (ADDRESS) *Gas W. Redglen Marshall Mo*

20. FILED *12/3* 19*32* *Clara Tutman* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Nov 29 1932*

22. I HEREBY CERTIFY, That I attended deceased from *off on front* 19*26*, to *Nov 28*, 19*32*
I last saw her alive on *Nov 28*, 19*32* Death is said to have occurred on the date stated above, at *12:50 P* m.

The principal cause of death and related causes of importance were as follows:

Heart failure
Pulmonary Tuberculosis
23A
23
Other contributory causes of importance:
Chronic bronchitis

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? *no*

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
If so, specify _____

(Signed) *Dr. J. S. Stearns*, M. D.
(Address) *Marshall 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.

