

REC'D AUG 7 1939

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

24447
Do not use this space.

1. PLACE OF DEATH

(a) County JACKSON 2 Registration District No. 399
 (b) Township RAW 1 Primary Registration District No. 1007 Registered No. 2660
 (c) City KANSAS CITY (d) Street No. 3817 WARWICK BLVD St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred 41 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

425 MRS ANNIE N. FAULNER
 (a) Residence, No. 3817 WARWICK BLVD St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

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 WILLIAM H. FAULNER
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) AUGUST 5 1857
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 81 10 29
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. AT HOME
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) JULY 3 1939
 22. I HEREBY CERTIFY, that I attended deceased from April 9th to June 23rd, 1939
 I last saw him alive on July 2, 1939. Death is said to have occurred on the date stated above, at 12:40 AM.
 The principal cause of death and related causes of importance were as follows:

Cerebral Haemorrhage
82a
 Other contributory causes of importance:
- Sessility -

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) INDIANAPOLIS INDIANA
 FATHER 13. NAME NAPOLEON B. LOBERG
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) KENTUCKY
 MOTHER 15. MAIDEN NAME NANCY A. RICE
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) KENTUCKY

Name of operation none Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? no

17. INFORMANT (ADDRESS) MRS LULU JENKINS 3817 WARWICK BLVD
 18. BURIAL, CREMATION, OR REMOVAL PLACE PL. FA. SAINT RIDGE CEM NEAR WESTAL, MO. DATE 7-5 39

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? no 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 _____

19. FUNERAL DIRECTOR (NAME) D. W. NEWCOMERTSONS
 (ADDRESS) 1401 BRUSH GREEN BLVD
 20. FILED July 3 1939 M. M. Brown Local Registrar.

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____
 (Signed) J. P. Thompson M. D.
 (Address) 311 1/2 4th St. Bldg
RC MO

X 18603

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.

RECORD WITH UPDATING INK—THIS IS A PERMANENT RECORD

Original copy

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed *E M Calhoun*
Licensed Embalmer No. *3506*
P. O. Address *K C Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.