

Registration District No. 213

Primary Registration District No. 3014

Registrar's No. 193

1. PLACE OF DEATH:

(a) County Cole
 (b) City or town Jefferson
 (c) Name of hospital or institution: 1006 Fairmount
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 7 yrs. (Specify whether years, months or days)

In this community 7 yrs. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Margaret Faulkner Lippage
 3. (b) If veteran, name war ✓
 3. (c) Social Security No. ✓

4. Sex F. 5. Color or race W
 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec. 11 1848
 (Month) (Day) (Year)

8. AGE: Years 92 Months 5 Days 20 If less than one day _____ hr. _____ min.

9. Birthplace Howell W. Ky.
 (City, town, or county) (State or foreign country)

10. Usual occupation Widow

11. Industry or business _____

MOTHER FATHER
 { 12. Name Jesse Faulkner
 { 13. Birthplace Ky.
 { 14. Maiden name Elizabeth Mearns
 { 15. Birthplace Ky.

16. (a) Informant's own signature Mrs. Gus Lippage
 (b) Address 1006 Fairmount - C. Mo.

17. (a) removal (b) Date thereof 7/31/40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. James, Mo.

18. (a) Signature of funeral director James W. ...
 (b) Address St. James, Mo.

19. (a) 7/31/40 (b) P. Bedford
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Cole
 (c) City or town Jefferson
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1006 Fairmount
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31
 year 1940 hour 9:0 minute A.M.

21. I hereby certify that I attended the deceased from 12-23, 1927 to 7-31, 1940
 that I last saw her alive on 7-30, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerosis
Chronic Myocarditis
 Due to Arteriosclerosis
 Due to Arteriosclerosis
 Other conditions (Include pregnancy within 9 months of death) 92

Duration 5 yrs
2 yrs
2 days
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically

Major findings: Of operations _____
 Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
 While at work? _____ (Specify type of place) _____
 (e) Means of injury _____

23. Signature D. W. Gillham M.D. (M. D. or other)
 Address Jefferson City 2210 Date signed 7-21-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

1006

Train 2nd

Blaker

1880
121
67

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.....

Licensed Embalmer No.....

P. O. Address.....

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.