

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28569
Registrar's No. 690

Registration District No. 18

Primary Registration District No. 5439

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield Rural
(c) Name of hospital or institution: County Farm Hospital 3
(d) Length of stay: In hospital or institution 2 years
In this community 33 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Rural
(d) Street No. Route # 11
(e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME BESSIE IVA FAULKNER

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Walter Faulkner 6. (c) Age of husband or wife if alive 45 years
7. Birth date of deceased: Unknown 1902

8. AGE: Years About 38 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Laclede County Missouri

10. Usual occupation None

11. Industry or business None
12. Name William Bridger
13. Birthplace Unknown Virginia
14. Maiden name Anna Boyden
15. Birthplace Unknown Tenn.

16. (a) Informant Walter L. Bridger

(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof Aug. 23, 1940

(c) Place: burial or cremation Wesley Chapel

18. (a) Signature of funeral director F. E. Thumme

(b) Address Springfield, Mo.

19. (a) Aug. 23, 1940 (b) W. E. Handley MD

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 22nd
year 1940 hour 11:25 minute A M.

21. I hereby certify that I attended the deceased from March 17
1940, to Aug 21, 1940;
that I last saw him alive on August 21, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary Tuberculosis 1938
Intestinal Tuberculosis

Due to _____

Due to _____

Other conditions: _____

Major findings: _____

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? _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Yes

While at work? _____ (Specify type of place) _____

(c) Means of injury _____

Signature E. C. Mucinda (M. D. or other) MD

Address Springfield Mo Date signed Aug 22, 40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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..... *R. H. [Signature]*

Licensed Embalmer No. *3681*

P. O. Address *Springfield, 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.