

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **28859**

FILED SEP 6 1949

BIRTH NO.		REG. DIST. NO. 317	PRIMARY REG. DIST. NO. 10076	Registrar's No. 2065
1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Missouri b. COUNTY unknow		
b. CITY (If outside corporate limits, write RURAL and give township) HEFTON		c. CITY (If outside corporate limits, write RURAL and give township) Jefferson City,		
d. FULL NAME OF HOSPITAL OR INSTITUTION MILLER NURSING HOME		d. STREET ADDRESS (If rural, give location) 717 E. McCarty St.		
3. NAME OF DECEASED (Type or Print) a. (First) James		b. (Middle) Milan		c. (Last) Faulk
4. DATE OF DEATH (Month) (Day) (Year) Aug. 26 1949		5. SEX Male		
6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced		8. DATE OF BIRTH ?
9. AGE (In years last birthday) Abt. 83		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired R. R. Telegrapher		10b. KIND OF BUSINESS OR INDUSTRY Railroad
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME John Faulk		13b. MOTHER'S MAIDEN NAME ?		14. NAME OF HUSBAND OR WIFE Bertha Johnson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Mrs. W. L. Gollahon
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Tuberculosis of spine ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 yr 7/20 2 yr.
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from P , 19 49 , to 8/26/49 , 19 49 , that I last saw the deceased alive on 8/26/49 , 19 49 , and that death occurred at L P. m., from the causes and on the date stated above.				
23a. SIGNATURE Walter A. Bell		23b. ADDRESS M. D., 3901. Shenandoah Ave.,		23c. DATE SIGNED 8/27/49
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 8/27/49		24c. NAME OF CEMETERY OR CREMATORY St. John's,
24d. LOCATION (City, town, or county) (State) St. John's, Kansas.		25. FUNERAL DIRECTOR'S SIGNATURE Ambruster Mort. 6633 Clayton Rd.		

(Licensed Embalmer's Signature on Reverse Side)

WRITE PLAINLY—USING UNFADEING BLACK INK—MAKE A PERMANENT RECORD

16
0

8-29-49

REGISTRAR'S SIGNATURE
Herbert R. ...

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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed _____

Ernest W. Spillers
4080

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, fact should be so stated above.