

FILED SEP 25 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29989

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 826

1. PLACE OF DEATH a. COUNTY <u>Greene</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u>	
c. LENGTH OF STAY (in this place) <u>1 day</u>		0396	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Burge Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>1107 East Central</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Charles</u> b. (Middle) <u>L</u> c. (Last) <u>Faulkner</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 18, 1950</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb 11, 1870</u>
9. AGE (in years last birthday) <u>80</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Blacksmith Shop</u>	13a. FATHER'S NAME <u>Isaac Faulkner</u>		13b. MOTHER'S MAIDEN NAME <u>Minerva A Crawford</u>
13c. NAME OF HUSBAND OR WIFE <u>Mrs Anna Faulkner</u>		14. NAME OF HUSBAND OR WIFE <u>Mrs Anna Faulkner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unk</u>	
17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs Anna Faulkner, Springfield, Mo.</u>			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cardio-Vascular-Renal Disease ?</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>442X</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., to or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	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 <u>Sept. 17, 1950</u> , to <u>Sept 18, 1950</u> , that I last saw the deceased alive on <u>Sept 17, 1950</u> , and that death occurred at <u>7:30A</u> m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>M. W. Gillman, M.D.</u>		23b. ADDRESS <u>Springfield, Mo.</u>	
23c. DATE SIGNED <u>9-20-50</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>Sept 20, 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Springfield, Missouri</u>
DATE REC'D BY LOCAL REG <u>9-21-50</u>	REGISTRAR'S SIGNATURE <u>W E Handley</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Alma Schmeyer, J. H. Springfield, Mo.</u>	

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

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SEP 27 1950

SEP 29 1950

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.

Signed Bernard F. Wright

Signed _____
Student Embalmer

Licensed Embalmer No. 4293

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, fact should be so stated above.