

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33184

State File No. \_\_\_\_\_

DECEASED OCT 15 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8949**

1. PLACE OF DEATH  
a. COUNTY \_\_\_\_\_  
2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
a. STATE **Missouri** b. COUNTY \_\_\_\_\_

b. CITY (If outside corporate limits, write RURAL and give OR TOWN **St. Louis, Missouri**) c. LENGTH OF STAY (in this place) \_\_\_\_\_  
c. CITY OR TOWN **St. Louis** d. Is Residence within limits of a city or incorporated town? Yes  No

d. FULL NAME OF HOSPITAL OR INSTITUTION **St. Louis City Hospital** e. STREET ADDRESS (If rural, give location) **226 3329 Klein St. 2269**

3. NAME OF DECEASED (Type or Print) a. (First) **JIM** b. (Middle) **J.** c. (Last) **FAULKNER** 4. DATE OF DEATH (Month) (Day) (Year) **SEPTEMBER 14, 1953**

5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **Widower** 8. DATE OF BIRTH **May 10, 1882.** 9. AGE (In years last birthday) **71.** IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)

10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) **Retired** 10b. KIND OF BUSINESS OR INDUSTRY **Farmer** 11. BIRTHPLACE (City and State or Foreign Country) **Dent County Missouri.** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13a. FATHER'S NAME **Dan Faulkner** 13b. MOTHER'S MAIDEN NAME **Susie Kennedy** 14. NAME OF HUSBAND OR WIFE **Emma**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **No.** (If yes, give war or dates of service) **NIL.** 16. SOCIAL SECURITY NO. **Unknown** 17. INFORMANT'S SIGNATURE OR NAME **Dessie Davis, 1402 Bremen.** ADDRESS \_\_\_\_\_

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, asphyxia, etc. It means the disease, injury, or complication which caused death.  
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) **Uremia, Using Asteneter**  
ANTECEDENT CAUSES **Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.** DUE TO (b) **Perforated Peptic Ulcer**  
DUE TO (c) \_\_\_\_\_  
II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION \_\_\_\_\_ 19b. MAJOR FINDINGS OF OPERATION **perforated Duodenal Ulcer.** 20. AUTOPSY? YES  NO

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) **541.1**

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) \_\_\_\_\_ 21e. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK  21f. HOW DID INJURY OCCUR? \_\_\_\_\_

22. I hereby certify that I attended the deceased from **9-7-53**, 19\_\_\_\_, to **9-14-53**, 19\_\_\_\_, that I last saw the deceased alive on **9-14-53**, 19\_\_\_\_, and that death occurred at **6:05A** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) **Robert W. Peltch M.D.** 23b. ADDRESS **1515 Lafayette Avenue** 23c. DATE SIGNED **9-14-53**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 24b. DATE **9-14-53.** 24c. NAME OF CEMETERY OR CREMATORY **Local** 24d. LOCATION (City, town, or county) (State) **Tronton, Mo.**

DATE REC'D BY LOCAL REG. **SEP 15 1953** REGISTRAR'S SIGNATURE **J. Carl Smith M.D.** 25. FUNERAL DIRECTOR'S SIGNATURE **Albert H. Hoppe** ADDRESS **4700 Washington.**

(Licensed Embalmer's Statement on Reverse Side)

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

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.....  
Signature of Student Embalmer

Signed *Robert M. Murray*

Licensed Embalmer No. *37498*

P. O. Address *St. Louis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.