

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-008470  
STATE FILE NUMBER

FILED MAR 23 1959

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 279

300  
1-57

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| 1. PLACE OF DEATH<br>a. COUNTY Buchanan  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Missouri b. COUNTY Buchanan |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN St. Joseph                |  | c. CITY OR TOWN St. Joseph  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION Mo. Meth. Hosp. |  | d. STREET ADDRESS (If outside, give location)<br>1600 Karnes Rd.  |  |

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|---|--|--|---|--|--|
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>Laura Deal Faulkner |  |  | 4. DATE OF DEATH<br>Month Day Year<br>March 15 1959 |  |  |
|---|--|--|---|--|--|

|                  |                           |   |                                   |                                       |                                |                                |
|------------------|---------------------------|---|-----------------------------------|---------------------------------------|--------------------------------|--------------------------------|
| 5. SEX<br>Female | 6. COLOR OR RACE<br>White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>Dec. 22, 1875 | 9. AGE (In years last birthday)<br>83 | IF UNDER 1 YEAR<br>Months Days | IF UNDER 24 HRS.<br>Hours Min. |
|------------------|---------------------------|---|-----------------------------------|---------------------------------------|--------------------------------|--------------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife | 10b. KIND OF BUSINESS OR INDUSTRY<br>At home | 11. BIRTHPLACE (City and state or country)<br>Wichita, Kansas | 12. CITIZEN OF WHAT COUNTRY?<br>USA |
|--|--|---|-------------------------------------|

|                                  |  |   |
|----------------------------------|--|---|
| 13a. FATHER'S NAME<br>James Deal | 13b. MOTHER'S MAIDEN NAME<br>Catherine Utz | 14. NAME OF HUSBAND OR WIFE<br>John S. Faulkner |
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|   |                         |                                    |                          |
|---|-------------------------|------------------------------------|--------------------------|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>No | 16. SOCIAL SECURITY NO. | 17. INFORMANT<br>Marguerite Griggs | Address<br>Savannah, Mo. |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Carcinoma Large bowel |  | INTERVAL BETWEEN ONSET AND DEATH<br>2 months |
| DUE TO (b) Carcinoma of Liver primary  |  |  |
| DUE TO (c)   |  | 1 year                                       |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) |
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| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m. p.m. | 20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION<br>COUNTY STATE |
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| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION<br>COUNTY STATE |
|--|--|--|

|   |  |
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| 21. I attended the deceased from<br>Death occurred at 11:28 P | to March 15 59 and last saw her alive on March 15 59 |
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| 22a. SIGNATURE<br><i>Owen W. Craig M.D.</i> | (Degree or title) | 22b. ADDRESS<br>520 Francis Street, St. Joseph Mo | 22c. DATE SIGNED<br>3/18/59 |
|---|-------------------|---|-----------------------------|

|   |                            |  |   |
|---|----------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial | 23b. DATE<br>Mar. 18, 1959 | 23c. NAME OF CEMETERY OR CREMATORY<br>Memorial Park Cemetery | 23d. LOCATION (City, town, or county)<br>St. Joseph, Missouri |
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| 24. FUNERAL DIRECTOR<br><i>Memorial Park</i> | ADDRESS<br>St. Joseph, Mo. | 25. DATE RECD. BY LOCAL REG.<br>Mar. 19, 1959 | 26. REGISTRAR'S SIGNATURE<br><i>Wm. Clark Howell</i> |
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(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

DR. OWEN W. CRAIG  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Louis J. Charney*

Licensed Embalmer No. 4679

P. O. Address St. Joseph, 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.