

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS FEB 16 1960

-60-006715

STATE FILE NUMBER

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 83

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Independence</u>		Length of stay in lb <u>3 Days</u>		c. CITY OR TOWN <u>Oak Grove</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Independence Hosp. San.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3 mi South of Oak Grove</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Faulkenberry</u> Middle <u>Curtis W.</u> Last <u>Faulkenberry</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>3</u> Year <u>1960</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 14 1889</u>	9. AGE (last birthday) <u>70</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (City and state or country) <u>Sci Mills community</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James Faulkenberry</u>			13b. MOTHER'S MAIDEN NAME <u>Sarah Smith</u>			14. NAME OF HUSBAND OR WIFE <u>Deceased</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>None</u>		17. INFORMANT <u>Hershall Cline</u> Address <u>Oak Grove Mo</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>2 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arterio Sclerosis Hypertis</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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.) _____						
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		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 _____		COUNTY _____		STATE _____	
21. I attended the deceased from <u>2-1-60</u> to <u>2-3-60</u> and last saw him <u>from</u> alive on <u>2-3-60</u> Death occurred at <u>5:12 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>James W. Davis M.D.</u>				22b. ADDRESS <u>Oak Grove Mo</u>			22c. DATE SIGNED <u>2/6/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2/6/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holiness Cemetery</u>		23d. LOCATION (City, town, or county) <u>Oak Grove</u>			23e. (State) <u>Mo</u>	
24. FUNERAL DIRECTOR <u>Webb Funeral Home</u> ADDRESS <u>Oak Grove Mo</u>				25. DATE RECD. BY LOCAL REG. <u>2-6-60</u>		26. REGISTRAR'S SIGNATURE <u>James L. Craig</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

88-2-0010-7

[Faint handwritten text]

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

~~or by~~ _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed William Fress

Licensed Embalmer No. 4731

P. O. Address Blue Springs

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.