

RECD APR 12 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 791

Do not fill this space.
8687

1. PLACE OF DEATH

(a) County 1 Registration District No. 1003
(b) Township 2 Primary Registration District No. _____
(c) City St. Louis (d) Street No. St. Johns Hospital St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Joseph V. Faulkner

(a) Residence, No. _____ St. NR Edmond Oklahoma
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Bessie Faulkner</u>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>2/6/1901</u>				
7. AGE YEARS <u>38</u>	MONTHS <u>1</u>	DAYS <u>8</u>	If LESS than 1 day, _____ hrs. or _____ min.	
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Driller (Well)</u>			
	9. Industry or business in which work was done, as saw mill, bank, etc. <u>Helmrich-Payne</u>			
	10. Date deceased last worked at this occupation (month and year) _____		11. Total time (years) spent in this occupation _____	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Muldrow Okla</u>				
FATHER	13. NAME <u>William Faulkner</u>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Okla.</u>			
MOTHER	15. MAIDEN NAME <u>Unknown</u>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Okla.</u>			
17. INFORMANT <u>Mrs. Bessie Faulkner</u> (ADDRESS) <u>Edmond Okla.</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Ft. Smith Ark.</u> DATE <u>3/15/39</u>				
19. INFORMANT DIRECTOR <u>Robert J. Ambruster</u> (ADDRESS) <u>6633 Clayton Road</u>				
20. FILED <u>MAR 15 1939</u> <u>J. B. Beck</u> Local Registrar				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3/14/39 1939

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

I last saw him _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at 4:40 P.

The principal cause of death and related causes of importance were as follows:

Removal was due to fracture of skull suffered when struck by iron pipe which had become disengaged from its support, while deceased was working on Oil Well about 3:20 P.M. Mar. 12, 1939

Other contributory causes of importance: _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide Accident Date of injury 3/12/39
Where did injury occur? St. Louis Mo
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. Industry

Manner of injury See above

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? yes
If so, specify Work on Oil Well
(Signed) W. G. Perry M.D.
(Address) Republic, Conn

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

STATEMENT BY LICENSED EMBALMER

I, Edward H. Bockhorst, Licensed Embalmer No. 2502

hereby certify that the body recorded on the reverse side of this certificate was embalmed by

L. E.

No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed

Edward H. Bockhorst

Licensed Embalmer No. 2502

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.)