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1948 OCT 11 1948  
DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

31003  
State File No. 3566  
Registrar's No.

Registration District No. 399 Primary Registration District No. 1002

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

1. PLACE OF DEATH:  
(a) County Jackson Co.  
(b) City or town Kansas City  
(c) Name of hospital or institution: St. Joseph Hospital  
(d) Length of stay: In hospital or institution 1 week  
In this community 1 week

3. (a) PRINT FULL NAME Elmer Faulkner  
(b) If veteran, name war No (c) Social Security No. 124

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Daisy Faulkner 6. (c) Age of husband or wife if alive 67 years  
7. Birth date of deceased June 16 - 1875

8. AGE: Years 65 Months 2 Days 24 If less than one day hr. min.

9. Birthplace Pleasant Hill Mo.

10. Usual occupation laundry driver

11. Industry or business  
12. Name Wm. M. Faulkner  
13. Birthplace Illinois  
14. Maiden name Esther White  
15. Birthplace Kentucky

16. (a) Informant Daisy Faulkner  
(b) Address Pleasant Hill Mo  
17. (a) Burial (b) Date thereof 9-12-40  
(c) Place of burial or cremation Union Baptist Cemetery Howard

18. (a) Signature of funeral director D. S. Winters  
(b) Address Pleasant Hill Mo  
19. (a) Sept. 12, 1960 (Date received local registrar) (b) D. S. Winters (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri, County Cass  
(c) City or town Pleasant Hill  
(d) Street No. Taylor Street  
(e) If foreign born, how long in U. S. A.? all of life years.

20. DATE OF DEATH: Month 9-10-40 year hour minute 3:55 P.M.

21. I hereby certify that I attended the deceased from Sept 10-40 to Sept 10-40, 1940; that I last saw alive on Sept 10-40, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia  
Due to Auto Injury of chest  
Due to Automobile Accidents  
Other conditions (include pregnancy within 3 months of death) 5-

Major findings: Of operations \_\_\_\_\_  
Of autopsy ab

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) Accident  
(b) Date of occurrence 9-3-40  
(c) Where did injury occur? Jackson Co Mo  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury 5  
23. Signature D. S. Winters (M. D. or other) \_\_\_\_\_  
Address Howard Date signed \_\_\_\_\_

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

210 A-

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 D. A. Noflinger Registered Apprentice No. \_\_\_\_\_ working under my personal supervision.

Signed D. A. Noflinger  
Licensed Embalmer No. 3958  
P. O. Address Pleasant Hill

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. 3566

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

1. PLACE OF DEATH:

(a) County Jackson  
 (b) City or town N.C.  
 (c) Name of hospital or institution Dr. Joseph Hosp.  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
 In this community \_\_\_\_\_ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
 (c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) If foreign born, how long in U. S. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Elmer Faulkner

(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years.

7. Birth date of deceased (Month) (Day) (Year) \_\_\_\_\_

8. AGE: Years Months Days If less than one year \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace (City, town, or county) (State or foreign country) \_\_\_\_\_

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace (City, town, or county) (State or foreign country) \_\_\_\_\_

14. Maiden name \_\_\_\_\_

15. Birthplace (City, town, or county) (State or foreign country) \_\_\_\_\_

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof (Month) (Day) (Year) \_\_\_\_\_

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 9/12/40 (b) M. M. Grove  
 (Date received local registrar) (Registrar's signature)

20. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ day 10-40  
 year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_;  
 that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to Crushing injury to chest  
Auto transport

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 710 72

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accid.

(b) Date of occurrence 9-3-40

(c) Where did injury occur Jackson Co. Mo  
 (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Highway Collision

While at work? Yes (Specify type of place) (e) Means of injury N.M.D.

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

Duration \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

5-31003