

40233

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 63

FILED DEC 22 1950

BIRTH NO. _____ REG. DIST. NO. 99 PRIMARY REG. DIST. NO. 4271 Registrar's No. 63

1. PLACE OF DEATH a. COUNTY <u>DeKalb Co</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>mo</u> b. COUNTY <u>DeKalb</u>		
b. CITY OR TOWN <u>CLARKSDALE</u>		c. LENGTH OF STAY (in this place) <u>1 yr.</u>	c. CITY OR TOWN <u>CLARKSDALE MO 0320</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION			d. STREET ADDRESS (If rural, give location)		

3. NAME OF DECEASED (Type or Print) <u>Charley E Farrington</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 4 1950</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>1</u>	8. DATE OF BIRTH <u>9-10-1877</u>		9. AGE (In years, month, day) <u>73</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MO</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					

13a. FATHER'S NAME <u>Wm H Farrington</u>		13b. MOTHER'S MAIDEN NAME <u>Salonia McDonald</u>		14. NAME OF HUSBAND OR WIFE <u>Lottie Farrington</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Lottie Farrington</u> ADDRESS <u>Clarkdale MO</u>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial Insufficiency</u>		DUE TO (b) <u>Cerebral Hemorrhage</u>			1 day	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c)			1 day	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					331X	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	

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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Dec. 3, 1950, to Dec. 4, 1950, that I last saw the deceased alive on Dec. 3, 1950 and that death occurred at 5 A. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Elmer J. King, M.D.</u>		23b. ADDRESS <u>Stewartville, Missouri</u>		23c. DATE SIGNED <u>12-8-50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>7</u>		24b. DATE <u>Dec 6 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Clarkdale</u>	
24d. LOCATION (City, town, or county) (State) <u>Clarkdale MO</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John Brown</u>		ADDRESS <u>Maynard, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>12-13-50</u>		REGISTRAR'S SIGNATURE <u>Aswore Davidson</u>		82	

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10:48



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
Student Embalmer

Signed _____

Licensed Embalmer No. 3933

P. O. Address Maple Hill, 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 this body is not embalmed, fact should be so stated above.