LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

25429

**1. PLACE OF DEATH**

County Texas — Registration District No. 863 — File No.

Township Piney — Primary Registration District No. 6137 — Registered No. 36

City ~~Houston~~ (No. ..... St. ..... Ward)

**2. FULL NAME** Jacob C Farley

(a) Residence No. ..... St., ..... Ward. .....
(Usual place of abode). (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Mary J Farley

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Dec 10 1842

7. AGE: Years 80 — Months 8 — Days 13 — If LESS than 1 day, ..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer): Farmer
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Tennessee

PARENTS

10. NAME OF FATHER: John M Farley
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Not Known
12. MAIDEN NAME OF MOTHER: Sarah Rogers
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Not Known

14. INFORMANT: Mrs. W. H. Price
(Address): 1204 W 4th St Springfield Mo

15. FILED 8-24 1922 J. N. Monnick, REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR): 8-23 1922

17. I HEREBY CERTIFY, That I attended deceased from on 8-23, 1922, to ....., 19.. that I last saw him alive on 8-23, 1922, and that death occurred, on the date stated above, at 9:30 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Lobar Pneumonia
10 d
unknown
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) E. P. Blankenship, M. D
, 19 (Address) Houston Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Oakhill — DATE OF BURIAL: 8-24-1922

20. UNDERTAKER: Gaylord & Elliott — ADDRESS: Cabool

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.

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Township..... Primary Registration District No..... Registered No. .....

City..... (No....., .....St. .....Ward)

**2. FULL NAME** .....

(a) Residence. No..... St., .....Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

## PERSONAL AND STATISTICAL PARTICULARS

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|---|---|---|
| | | |

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, .....hrs. or .....min. |
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| | | | | |

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(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14.
INFORMANT .....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

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I HEREBY CERTIFY, That I attended deceased from .....
.....,19....., to ....., 19.....
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THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....
.....
.....
.....(duration).....yrs. .....mos. .....ds.

CONTRIBUTORY.....
(SECONDARY)
.....(duration).....yrs. .....mos. .....ds.

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(Signed)....., M. D
, 19 (Address)

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|---|---|
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