

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

Do not use this space.

16278

1. PLACE OF DEATH
 County Buchanan Registration District No. 85
 Township _____ Primary Registration District No. 1001
 City St. Joseph (No. 416 South 20th Street) St. _____ Ward _____

File No. _____
 Registered No. 678

2. FULL NAME Jennie May Farmer
 (a) Residence No. 416 South 20th Street St. _____ Ward _____
 (Usual place of abode)
 Length of residence in city or town where death occurred 19 yrs. _____ mos. _____ ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) January 18, 1868

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>60</u>	<u>4</u>	<u>5</u>	

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

9. BIRTHPLACE (CITY OR TOWN) Hamilton
 (STATE OR COUNTRY) Ohio

10. NAME OF FATHER William Hively
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Unknown
 (STATE OR COUNTRY) Unknown
 12. MAIDEN NAME OF MOTHER Unknown
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown
 (STATE OR COUNTRY) Unknown

14. INFORMANT Mrs Everett Parker
 Address 416 South 20th Street

15. FILED 25 1928
John G. Up REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 23 19 28

17. I HEREBY CERTIFY That I attended deceased from 5/22 1928 to 5/23 1928 that I last saw h. or alive on 5/23 1928, and that death occurred, on the date stated above, at 9:25 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

131
12/29/90
Central Apoplexy -
 (duration) _____ yrs. _____ mos. 7 ds.
 CONTRIBUTORY Substituted Nephritis
 (SECONDARY) about
 (duration) _____ yrs. 4 mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED at home
 IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____
 WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS Phys -
 (Signed) R. B. Simmons, M. D.
5/24/ 19 28 (Address) St Joseph - 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mount Auburn Cemetery DATE OF BURIAL May 25 19 28

20. UNDERTAKER H. O. Sidusader ADDRESS 1802 Union St.

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.

WRITE FULLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

