

22 1929

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

Do not use this space.

40021

1. PLACE OF DEATH

County Crawfords
Township Liberty
City (No.) St. Ward)

Registration District No. 233
Primary Registration District No. 5218

File No.
Registered No. 281

2. FULL NAME

Ben Goot Farris

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
(Preceded by the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 28 - 1852

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hr. or min.
76 10 16

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farming
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) West Virginia
(STATE OR COUNTRY)

10. NAME OF FATHER Came Farris

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Not known

12. MAIDEN NAME OF MOTHER Felbe Harman

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Not known

14. INFORMANT Alice L. Wymer
(Address) Bowling Mo.

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

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 14 - 1928

17. I HEREBY CERTIFY, That I attended deceased from Dec 13 to Dec 14, 1928
that I last saw him alive on Dec 13, 1928, and that death occurred, on the date stated above, at 2:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral hemorrhage - Apoplexy
87A

CONTRIBUTORY (SECONDARY)

74A
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH at place of death

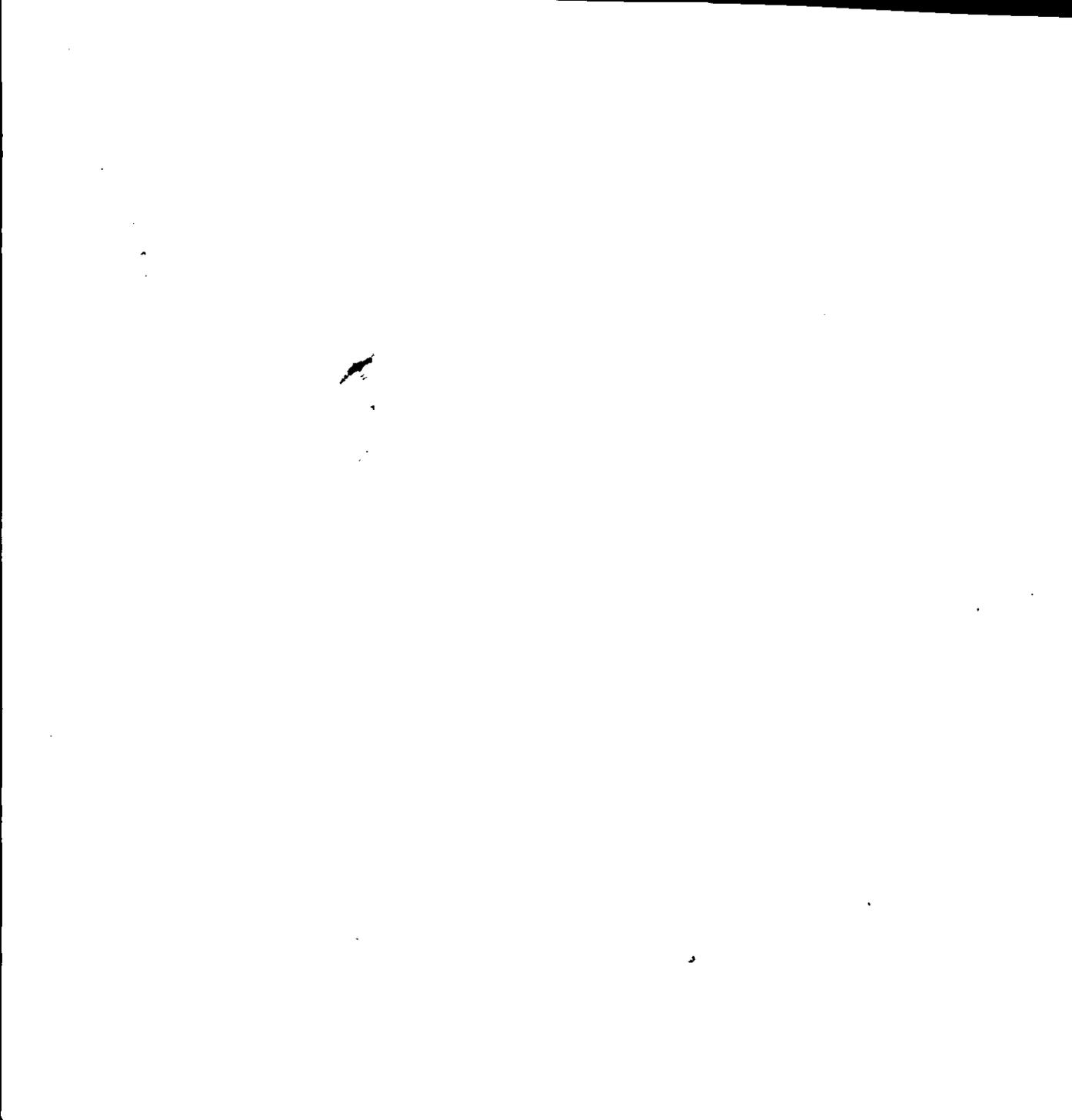
19. DID AN OPERATION PRECEDE DEATH... no DATE OF...
WAS THERE AN AUTOPSY... no

WHAT TEST CONFIRMED DIAGNOSIS Clinical
(Signed) H. G. Truman, M. D.
4014, 1928 (Address) Learburg 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 Fairview Cemetery DATE OF BURIAL Dec 16 1928

20. UNDERTAKER H. Linstromberg ADDRESS Bowling Mo.



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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Crawford
Township Liberty
City (No. _____) _____

Registration District No. 233
Primary Registration District No. 5218

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Ben Yost Harris

(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) W

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 11/28/1852

7. AGE YEARS MONTHS DAYS 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) _____

(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) _____

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. Dec 15 28 W. F. Train M.D.
FILED _____ 19 _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/14 1928

17. I HEREBY CERTIFY That I attended deceased from _____, 19____ to _____, 19____ that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, _____, 19____.

THE CAUSE OF DEATH WAS AS FOLLOWS:

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

*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

DATE OF BURIAL

19 _____

20. UNDERTAKER

ADDRESS

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

12004-S