

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

Do not use this space.

11633

1. PLACE OF DEATH

County St. Louis Registration District No. 274 File No. _____
 Township Lilbourn Primary Registration District No. 4063 Registered No. _____
 City Lilbourn St. _____ Ward _____

2. FULL NAME Laraine C. Farris

(a) Residence No. _____ St. _____ Ward _____ (If nonresident give city or town and State)
 (Usual place of abode)
 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) _____

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr 18 1925

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>3</u>	<u>10</u>	<u>23</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Lilbourn
 (STATE OR COUNTRY) _____

10. NAME OF FATHER Miffie Farris

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

12. MAIDEN NAME OF MOTHER May Welden

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

14. INFORMANT Miffie Farris
 (Address) Lilbourn

15. FILED Feb 11 1929 E. E. Jones
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 18 1929

17. I HEREBY CERTIFY, That I attended deceased from March 10 1929, to March 11 1929, that I last saw him alive on March 11 1929, and that death occurred, on the date stated above, at 2:40 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Polio myelitis

CONTRIBUTORY (SECONDARY) _____

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH? _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? none

(Signed) G. J. Jones, M. D.

(Address) Lilbourn 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.

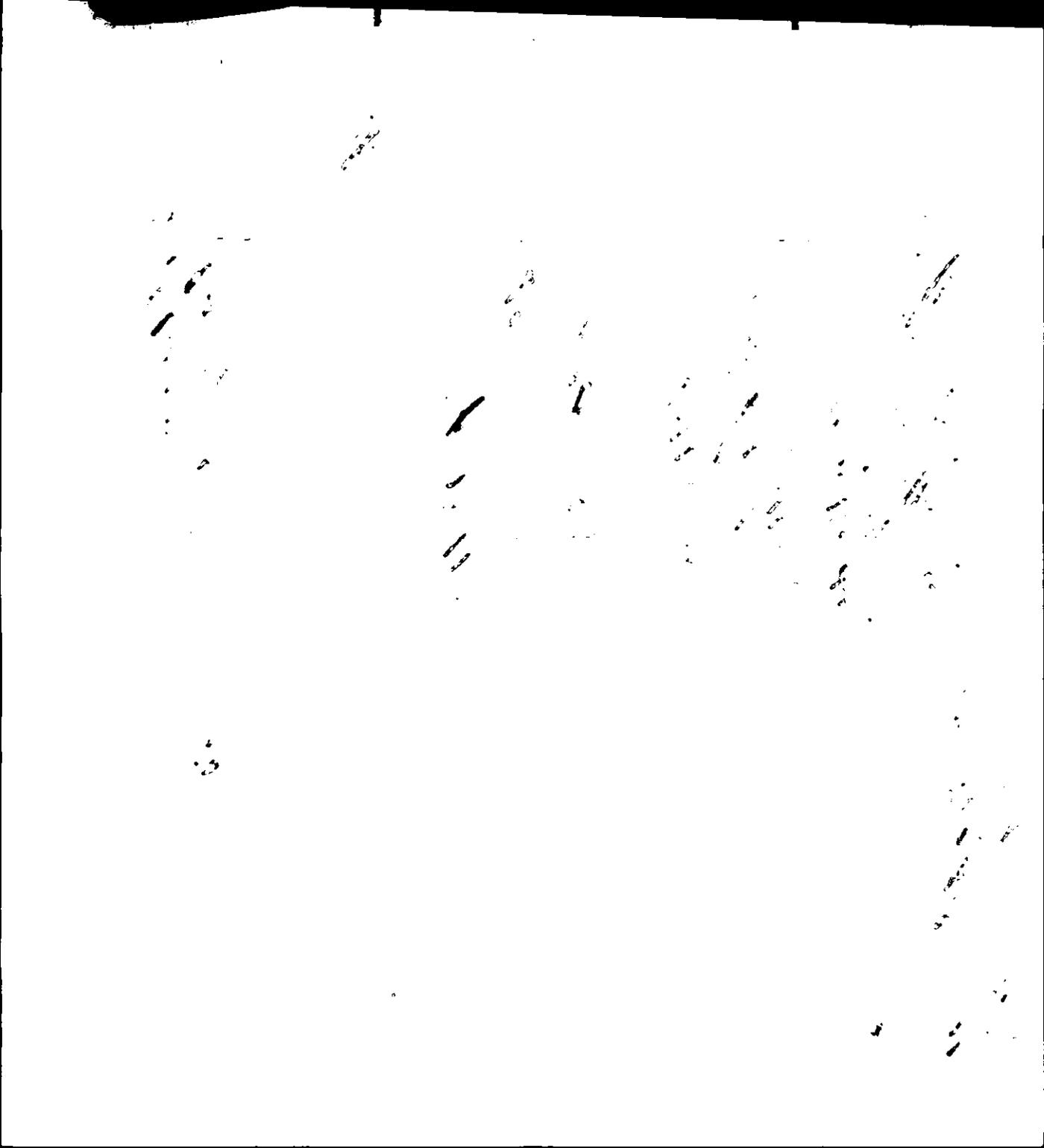
19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____

20. UNDERTAKER L. M. Hill

ADDRESS Lilbourn

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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 1



requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate:

Name: Larkin C. Harris

Who died at: Lilbourn, Mo, Mar. 11, 1929

Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex: _____ Color or race: _____ Single, married, widowed or divorced: _____

Date of birth: _____ Age: Years _____ Months _____ Days _____

Occupation: (a) Trade _____ (b) Industry: _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

CAUSE OF DEATH: Polio myelitis
(Acute anterior)

Contributory: _____

Where was disease contracted? _____

Did operation precede death? _____ Date of _____

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