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

Do not use this space.

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1. PLACE OF DEATH
County Jackson
Township Kaw
City 7 & C Mo Gen Hospital #2
Registration District No. 399
Primary Registration District No. 4002
File No. 1782
Registered No. 1782
St. Ward)

2. FULL NAME Tom Farrow
(a) Residence. No. 934 Bell St., 1 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 Male
4. COLOR OR RACE Negro
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Widow
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown
7. AGE Years about 64 Months Days If LESS than 1 day, ...hrs. or ....min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(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) Tyler Texas

PARENTS
10. NAME OF FATHER Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER Caroline Farrow
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Springfield Mo

14. INFORMANT Ray Brown
(Address) 934 Bell St
15. FILED 4/15, 1929 M. M. Crowe Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-13-1929
17. I HEREBY CERTIFY, That I attended deceased from Deputy Coroner, 19.., to ....., 19.., that I last saw h..... alive on ....., 19.., and that death occurred, on the date stated above, at ....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Accidental
18A Concussion of Brain
19A (duration) ....yrs. ....mos. ....ds.
CONTRIBUTORY (SECONDARY) Fell in Subway
(duration) ....yrs. ....mos. ....ds.

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18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? autopsy
(Signed) [signature], M. D
4/13/29 (Address) Deputy Coroner

*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 Westlawn Cemetery
DATE OF BURIAL 4-16 1929
20. UNDERTAKER Jul. A. Fichlin
ADDRESS 1209 Vine

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

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.

V. S. N. 2. 3/2 237