

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

Do not use this space.

26483

**1. PLACE OF DEATH**

County..... Registration District No. 791  
 Township..... Primary Registration District No. 1003  
 City St. Louis, Mo. (No. 3404 Hartford)

File No.....  
 Registered No. 7747  
 St. .... Ward)

**2. FULL NAME**

French Farrow  
 (a) Residence. No. 3404 Hartford St., 16 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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>April 3-1870</u>		
7. AGE	YEARS	MONTHS
	<u>59</u>	<u>3</u>
		DAYS
		<u>22</u>
8. OCCUPATION OF DECEASED		
(a) Trade, profession, or particular kind of work <u>Insurance</u>		
(b) General nature of industry, business, or establishment in which employed (or employer) <u>Business</u>		
(c) Name of employer		

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill.

10. NAME OF FATHER Halloway Farrow

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Ida May Farrow  
 (Address) 3404 Hartford

15. FILED 1 26 1929 W. C. Starkeff  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 25-1929  
 17. I HEREBY CERTIFY, That I attended deceased from July 29, 1929, to July 25, 1929, that I last saw alive on July 25, 1929, and that death occurred, on the date stated above, at 7:15 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Valvular Disease of Heart  
92%  
 (duration) but yrs. 0 mos. .... ds.

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

18. WHERE WAS DISEASE CONTRACTED  
9000  
 (duration) .... yrs. .... mos. .... ds.

DID AN OPERATION PRECEDE DEATH? no DATE OF  
 WAS THERE AN AUTOPSY? no  
 WHAT TEST CONFIRMED DIAGNOSIS? Clinical symptoms  
 (Signed) W. V. Vaughan, M. D.  
7/25, 1929. (Address) 4900 Washington

\*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 Medora Ill. DATE OF BURIAL 7-27-1929

20. UNDERTAKER Ziegenbein Bros. 2623 Cherokee  
 ADDRESS

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.

MARGIN RESERVED FOR BINDING

V. 5890. 2.

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