MAY 27 1930

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

Do not use this space 13692 / 13626

1. PLACE OF DEATH
County: Ray
Township: Camden
City: / (No. ... St. ... Ward)

Registration District No. 739
Primary Registration District No. 4441

File No.
Registered No.

2. FULL NAME: Mary Bell Farris (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. 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): Infant

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Apr 17 1930

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or 42 min.
0	0	0	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Infant
(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): Ray Co Mo

PARENTS
10. NAME OF FATHER: Clarence M Farris
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ray Co Mo
12. MAIDEN NAME OF MOTHER: Irene Coney
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Orrick Mo

14. INFORMANT: Clarence Farris
(Address) Orrick Mo.

15. FILED: Mar 28 1930 W. W. Burgess REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Apr 17 1930

17. I HEREBY CERTIFY, That I attended deceased from April 17, 1930, to April 17, 1930 that I last saw h. alive on April 17, 1930 and that death occurred, on the date stated above, at 8.12 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Premature

159 (duration) yrs. mos. 1 ds.

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

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? Clinical
(Signed) L. E. Ellis, M. D.
Apr 18, 1930 (Address) Orrick 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: Smith Point Cem. DATE OF BURIAL: Apr 17 1930

20. UNDERTAKER: No Undertaker ADDRESS: ✓

N. B. ... should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain ... properly classified. Exact statement of OCCUPATION is very important.

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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

N. B.—Every item of information should be careful[illegible] AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH [illegible] properly classified. Exact statement of OCCUPATION is very important.

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

1. PLACE OF DEATH

County: Ray — Registration District No.: 739 — File No.:

Township: Camden — Primary Registration District No.: 4441 — Registered No.:

City: — (No. ..... St. ..... Ward)

2. FULL NAME: Mary Bell 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: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): S

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

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

7. AGE — YEARS — MONTHS — DAYS — If LESS than 1 day, ... hrs. or 42 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 COUNTY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTY)

14. INFORMANT
(Address)

15. FILED 6-19, 19 W. W. Burgess
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 17 1930

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, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Prematurity

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY)

(duration) ..... yrs. ..... mos. ..... ds.

SUPPLEMENTARY

16th

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

S-13692