

NOV 26 1930

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

Do not use this space.

33812

1. PLACE OF DEATH *July 1*
 County *Montgomery* Registration District No. *702*
 Township *Fair Play* Primary Registration District No. *4423*
 City *Fair Play* St. _____ Ward _____

2. FULL NAME *Mary W. Walkerin Farr*
 (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. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female*
 4. COLOR OR RACE *White*
 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Widowed*
 (write the word)
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Arthur B. Farr*
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Oct 25, 1854*
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
75 // 10
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work *Housekeeper*
 (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) *Montgomery Co Mo*
 10. NAME OF FATHER *Wm Summers*
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Fair Play*
 12. MAIDEN NAME OF MOTHER *Catherine Shalk*
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Fair Play*

14. INFORMANT *Ella Underwood*
 (Address) *Fair Play Mo*
 15. FILED *9/10* 19 *30* *Chas H Brown*
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Oct 10* 19 *30*
 17. I HEREBY CERTIFY, That I attended deceased from *July 29*, 19 *29*, to *Oct 10*, 19 *30*, that I last saw *her* alive on *July 29*, 19 *29*, and that death occurred, on the date stated above, at *19 29 AM* m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Causes of bowels
 (duration) *1* yrs. mos. 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 *11*
 WAS THERE AN AUTOPSY? *No*
 WHAT TEST CONFIRMED DIAGNOSIS? *clinical*
 (Signed) *Chas H Brown*, M. D.
 (Address) *Fair Play 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 HOSPITAL.
 19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Stony Brook Cem* DATE OF BURIAL *Oct 11* 19 *30*
 20. UNDERTAKER *Abe Joseph* ADDRESS *Hennault*

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.

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