

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

Do not use this space.

1. PLACE OF DEATH

County Greene Registration District No. 318
Township Springfield Primary Registration District No. 204
City Springfield (No. _____, _____ Ward)

File No. 9528
Registered No. 219

2. FULL NAME

John Roy Farmer
(a) Residence No. 2000 Home Dr. Springfield, Mo. (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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED single
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 8-4-1920
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
10 7 14

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bethune Mo.
13. NAME Warren Farmer
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Boadua Mo.
15. MAIDEN NAME Ida Wells
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pack Mo.

17. INFORMANT Mrs. Warren Farmer
(ADDRESS) Greene Mo.
18. BURIAL, CREMATION, OR REMOVAL PLACE Boadua Mo. DATE May 20, 1931

19. UNDERTAKER Whitehead, Eugene
(ADDRESS) Boadua Mo.
20. FILED 5-19-31 John Sharp Registrar.

7 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-19-31
22. I HEREBY CERTIFY, That I attended deceased from 3-19, 1931, to 3-19, 1931
I last saw him alive on 3-19, 1931. Death is said to have occurred on the date stated above, at 11 A.m.
The principal cause of death and related causes of importance were as follows:

meningitis
non epidemic
IB
79A
Other contributory causes of importance:
First had influenza

Name of operation _____ Date of _____
What test confirmed diagnosis _____ Was there an autopsy? _____

23. If death was due to external cause (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____
Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) Paul Anderson, M. D.
(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.

APR 23 1931

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