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.

AUG 14 1935

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

Do not use this space.

22467

1. PLACE OF DEATH

County Clay — Registration District No. 198 — File No.

Township ~~Fishing River~~ — Primary Registration District No. 3011 — Registered No.

City Veterans Administration Facility, Excelsior Springs, Mo St. 34 Ward)

2. FULL NAME FARR, Basil

(a) Residence, No. Vets. Adm. Facility, Excelsior Springs, Mo. Polo, Missouri
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 28 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 (*write* the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF ~~[illegible]~~ Aynlah Farr

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

7. AGE: YEARS 40 — MONTHS 7 — DAYS 27 — If LESS than 1 day, ....hrs. or ....min.

OCCUPATION

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Polo, Missouri

FATHER

13. NAME Charles Farr
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hamilton, Missouri

MOTHER

15. MAIDEN NAME Cora Wheat
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

17. INFORMANT (ADDRESS) Hospital Records

18. BURIAL, CREMATION, OR REMOVAL
PLACE Polo, Missouri DATE 7-22-35, 19

19. UNDERTAKER (ADDRESS) John C. Prather, Undertaker Excelsior Springs, Mo.

20. FILED 7-21-, 1935 Mrs Rea M. Cracklin Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 21, 1935, 19

22. I HEREBY CERTIFY, That I attended deceased from June 23, 1935, 19, to July 21, 1935, 19

I last saw him alive on July 21, 1935, 19 Death is said to have occurred on the date stated above, at 7:15 x P.M.

The principal cause of death and related causes of importance were as follows:

Date of onset

Carcinoma of stomach with metastasis mesentery glands

Other contributory causes of importance:

Fibrinous peritonitis

46

Name of operation Date of

What test confirmed diagnosis Exam & Obs Was there an autopsy? yes

23. If death was due to external causes (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) H.C. HARDEGREE, MD, Clinical Director M. D.
Veterans Administration Facility
(Address) Excelsior Springs, Mo.

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

Do not use this space.

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

1. PLACE OF DEATH

County Clay — Registration District No. 198 — File No.

Township — Primary Registration District No. 3014 — Registered No.

City — (No. Veterans Adm. Facility St. Ward)

2. FULL NAME Farr, Basil

(a) Residence, No. St., Ward. Polo, Mo
(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 M

4. COLOR OR RACE W

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) (11-25-1894)

7. AGE

| YEARS | MONTHS | DAYS | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 40 | 7 | 27 | |

OCCUPATION

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)

FATHER

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. UNDERTAKER (ADDRESS)

20. FILED 7-21 1935 Mrs. Rea McCrosskin Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 21, 1935

22. I HEREBY CERTIFY, That I attended deceased from , 19, to , 19

I last saw h alive on , 19 Death is said to have occurred on the date stated above, at m.

The principal cause of death and related causes of importance were as follows:

| | Date of onset |
|---|---|
| | |

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (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) , M. D.

(Address)

SUPPLEMENTARY

N.B. Every [illegible] 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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