

DEC'D FEB 24 1939

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

2995  
Do not use this space.

## 1. PLACE OF DEATH

(a) County Monroe Registration District No. 532  
(b) Township LaPlatan Primary Registration District No. 5711 Registered No. \_\_\_\_\_  
(c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

## 2. PRINT FULL NAME

Anna Farden  
(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Henry Farden  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 13-1878  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
60 4 8  
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as saw mill, bank, etc. Housekeeper  
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) Osceola Ill  
13. NAME James Owens  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland  
15. MAIDEN NAME Allie Ryan  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois  
17. INFORMANT (ADDRESS) Henry Farden  
LaPlatan Mo  
18. BURIAL, CREMATION, OR REMOVAL PLACE LaPlatan Mo DATE Jan 23 1939  
19. FUNERAL DIRECTOR (NAME) (ADDRESS) D. G. Christie  
LaPlatan Mo  
20. FILED Jan 23 1939 Louise J. Smith  
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 21 1939  
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 11 a. m.  
The principal cause of death and related causes of importance were as follows:  
Committed Suicide by shooting with a 2 1/2 Caliber Rifle Date of onset Jan 21 1939  
Other contributory causes of importance: Insanity 167 1937  
Name of operation none Date of \_\_\_\_\_  
What test confirmed diagnosis? observed Was there an autopsy? no  
23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? suicide Date of injury Jan 21 1939  
Where did injury occur? at her home  
(Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place. at her home  
Manner of injury shot  
Nature of injury \_\_\_\_\_  
24. Was disease or injury in any way related to occupation of deceased? no  
If so, specify \_\_\_\_\_  
(Signed) Chas. West M. D.  
(Address) New Orleans Mo

RECEIVED  
District Health Officer No. 10  
District File Number 10-39-127  
FEB 7 1939  
Date Filed

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, .....

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**