

MAR 23 1939

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

Do not use this space.  
8150

1. PLACE OF DEATH *Webster*

(a) County *Webster* Registration District No. *897*

(b) Township *Seymour* Primary Registration District No. *4543*

(c) City *Seymour* (d) Street No. \_\_\_\_\_ (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. *12* (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME *Earl J. Farbs*

(a) Residence, No. *Seymour Mo.* St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male*

4. COLOR OR RACE *white*

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Jan 23 - 1938*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<i>1</i>		<i>12</i>	

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. *None*

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) *Seymour Mo.*

FATHER

13. NAME *Earl Farbs*

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

MOTHER

15. MAIDEN NAME *Barnett Dudley*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Seymour Mo.*

17. INFORMANT (ADDRESS) *Earl Farbs Seymour Mo.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Masonic Club* DATE *2-6-39*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *McMahon & Wilson Seymour Mo.*

20. FILED *2-6-39* *R.E. McMahon* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Feb - 5 1939*

22. I HEREBY CERTIFY, That I attended deceased from *2-2-39* to *2-5-39*

I last saw him alive on *2-5-39* Death is said to have occurred on the date stated above, at *3 P.* m.

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

Date of onset \_\_\_\_\_

Other contributory causes of importance:  
*Brain Head Injury by a fall about 36 days ago.*

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 *1-4-39*

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) *[Signature]*, M. D.

(Address) *[Address]*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

RETURN TO CHAS. W. BENTLEY, JR.  
DISTRICT HEALTH OFFICER  
BOSTON, MASS.

District Health Officer No. 6,

District File Number 6-39-453

Date Filed MAR 3 1939



**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.**