

1939 JUN 14 1939

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

18120
Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 85
(b) Township Washington Primary Registration District No. 1001 Registered No. 564
(c) City St. Joseph or (d) Street No. Mo. Meth. Hospital 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 MRS. VIRGINIA FARRIS

(a) Residence, No. R.R. 2 St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 9th. 1876

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
63 2 22

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as 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) Hausville (STATE OR COUNTRY) Ky.

13. NAME John W. Brunner

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

15. MAIDEN NAME Louisana Rice

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

17. INFORMANT J.M. Ousley (ADDRESS) Lee Summit, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Register Cemetery June 2nd. 1939

19. FUNERAL DIRECTOR (NAME) FLEEMAN & SON INC (ADDRESS) 1946 Calhoun St. Joseph, Mo.

20. FILED June 2 1939 A. J. Seallebrush Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 31st. 1939

22. I HEREBY CERTIFY, That I attended deceased from May 29, 1939, to May 31, 1939

I last saw her alive on May 31, 1939. Death is said to have occurred on the date stated above, at 6 p. m.
The principal cause of death and related causes of importance were as follows:

Re. Emphysema

Date of onset 5-25-39

Other contributory causes of importance:

Name of operation none Date of
What test confirmed diagnosis clinical Was there an autopsy? no

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? no
If so, specify

(Signed) H. B. Kearby, M. D.
(Address) St. Joseph, Mo.

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 impor-

1102

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.....

John E. Rupp

Licensed Embalmer No.....

3986

P. O. Address.....

St. Joseph, Mo

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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CERTIFICATE OF DEATH

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Do not use this space.

1. PLACE OF DEATH

(a) County Buchanan Registration District No. 85-
(b) Township St Joseph Primary Registration District No. 1001 Registered No. 564
(c) City St Joseph (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 Mrs. Virginia Ferris

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-31 1917

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

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

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
63 2 22

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

OCCUPATION
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.
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

ac. Respyrenia
Date of onset _____

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

Other contributory causes of importance:
unknown

FATHER
13. NAME

Name of operation _____ Date of _____

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

What test confirmed diagnosis? _____ Was there an autopsy? _____

MOTHER
15. MAIDEN NAME

23. If death was due to external causes (violence), fill in also the following:

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

Accident, suicide, or homicide? _____ Date of injury _____, 19____

17. INFORMANT (ADDRESS)

Where did injury occur? _____ (Specify city or town, county, and State)

18. BURIAL, CREMATION, OR REMOVAL

Specify whether injury occurred in industry, in home, or in public place.

PLACE _____ DATE _____ 19____

Manner of injury _____

Nature of injury _____

19. FUNERAL DIRECTOR (ADDRESS)

24. Was disease or injury in any way related to occupation of deceased? _____

20. FILED _____ 19____

If so, specify _____ (Signed) H. D. Kearsley, M. D.

(Address) St Joseph Mo

Local Registrar.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

JUN 14 1939