

SEP 6 1939

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

29534
Do not use this space.

1. PLACE OF DEATH

(a) County Lawrence Registration District No. 467
(b) Township AURORA Primary Registration District No. 4280 Registered No. 49
(c) City Aurora (d) Street No. 111 East Locust 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 Mollie J Farrell

(a) Residence, No. 111 East Locust St. 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 (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 25-1860

7. AGE YEARS 79 MONTHS 4 DAYS 19 If LESS than 1 day, hrs. or min.

OCCUPATION 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) (STATE OR COUNTRY) Scranton Pa.

FATHER 13. NAME John Donovan

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

MOTHER 15. MAIDEN NAME Johanna Carroll

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

17. INFORMANT (ADDRESS) Mrs Kate Balzer, Des Moines Iowa.

18. BURIAL, CREMATION, OR REMOVAL PLACE Aurora Mo. DATE AUG 17 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. F. King Aurora Mo.

20. FILED 9-2 1939 B. D. Cavan, MD Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) August 14 1939

22. I HEREBY CERTIFY, That I attended deceased from 6-22 1939, to 8/14 1939
I last saw HT alive on 8/12 1939. Death is said to have occurred on the date stated above, at 4:30 A.M.
The principal cause of death and related causes of importance were as follows:

Myocarditis
arterio-sclerosis
Date of onset not known

Other contributory causes of importance:
arterio-sclerosis

Name of operation Cholecystectomy Date of 8/14/39
What test confirmed diagnosis? Cholecystectomy 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) Wm. Smith, M. D.
Address 121 W. Pleasant Aurora Mo.

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.

30M-19-38 I X16605

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.....

Herman Surridge

Licensed Embalmer No. *3072*

P. O. Address *Curran 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.