

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.

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

32291
Do not use this space.

1. PLACE OF DEATH

(a) County DEKALB Registration District No. 258
 (b) Township WASHINGTON Primary Registration District No. 4157
 (c) City CLARKSDALE (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

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
652 LEVYIS FARRINGTON

PERSONAL AND STATISTICAL PARTICULARS

3. SEX MALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED WIDOWED
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF MARILINDA FARRINGTON
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) OCTOBER 7 1848
 7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
90 10 24
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. RETIRED FARMER
 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 _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9/1 1939
 22. I HEREBY CERTIFY, That I attended deceased from 8-29- 1939, to 8-31- 1939
 I last saw him alive on 8-31- 1939. Death is said to have occurred on the date stated above, at 2 a.m.
 The principal cause of death and related causes of importance were as follows:
Myocardial Degeneration
93C
 Other contributory causes of importance:
Senile Softening of Brain 1938

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) North Co. Mo
 FATHER 13. NAME EUSTON FARRINGTON
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) UNKNOWN
 MOTHER 15. MAIDEN NAME KATE GIMBERLIN
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) UNKNOWN
 17. INFORMANT (ADDRESS) Orlen Farrington Clarksdale, Mo
 18. BURIAL, CREMATION, OR REMOVAL CLARKSDALE CEM. DATE 9/2 39
 19. FUNERAL DIRECTOR (ADDRESS) Decher FUNERAL HOME MAYSVILLE Mo.
 20. FILED 9/2 1939 Mrs C M Davis Local Registrar.

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) O. L. Perkins, M. D.
223 (Address) Clarksdale Mo

District No. 11,
District File No. 1039-1289
Date Filed OCT 11 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 *J. L. Ditcher*
Licensed Embalmer No. *3960*
P. O. Address *Maple Hill 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.