DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Sept 10 1939

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 32297

Registration District No. 266 Primary Registration District No. 4164 Registrar's No. 74

1. PLACE OF DEATH: 2

(a) County Dent

(b) City or town Salem ~~Springcreek~~
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: ---
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution --- (Specify whether
In this community --- years, months or days)

2. USUAL RESIDENCE OF DECEASED: 1

(a) State Missouri (b) County Dent

(c) City or town Salem
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Doyle Ervin Farrar 660

3. (b) If veteran, name war --- 3. (c) Social Security No. ---

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife --- 6. (c) Age of husband or wife if alive ----- years

7. Birth date of deceased Sept 12 (Month) 1939 (Day) (Year)

8. AGE: Years Stillbirth Months Days If less than one day hr. min.

9. Birthplace Salem (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Stillbirth 0

11. Industry or business 0

FATHER
12. Name Johnie Dow Farrar 0
13. Birthplace Salem (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Velma Irene Callahan
15. Birthplace Salem (City, town, or county) Missouri (State or foreign country)

16. (a) Informant's own signature Opie Farrar
(b) Address Salem, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/12/39 (Month) (Day) (Year)
(c) Place: burial or cremation Cedar Grove Cem

18. (a) Signature of funeral director Carl R. Spencer
(b) Address Salem, Missouri

19. (a) September 12 1939 (Date received local registrar) (b) F. E. Hutte M.D. 240 (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day Sept. year 1939 hour 3 minute 30 A M.

21. I hereby certify that I attended the deceased from , 19 , to Sept. 12 , 1939; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Stillborn	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature Marvin Grossman (M. D. or other) MD
Address Salem Mo Date signed 9/12/39

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

1 X19511

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.

RECEIVED

District Health Officer No. 5,

District File Number 1039 278

Date Filed 10 6 39

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

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