

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

33206

Do not use this space.

OCT 19 1939

1. PLACE OF DEATH

(a) County Pattis Registration District No. 669
 (b) Township _____ Primary Registration District No. H451
 (c) City Smithton (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 James H. Farner

(a) Residence, No. Smithton, Missouri 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 Male 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 Alicia
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 9, 1883
 7. AGE YEARS 56 MONTHS 3 DAYS 3 If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Distributor
 9. Industry or business in which work was done, as saw mill, bank, etc. Newspaper
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) Smithton, Missouri

FATHER 13. NAME Jacob J. Farner
 14. BIRTHPLACE (CITY OR TOWN) Greenville, Tenn.

MOTHER 15. MAIDEN NAME Anna Ringen
 16. BIRTHPLACE (CITY OR TOWN) Lake Creek, Mo.

17. INFORMANT Mrs. Alicia Farner,
 (ADDRESS) Smithton, Missouri

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Smithton, Missouri DATE 9/14/39

19. FUNERAL DIRECTOR (NAME) Gillespie Funeral Home
 (ADDRESS) Sedalia, Missouri

20. FILED 9-14-39 W. J. Monahan
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) September 12, 1939

22. I HEREBY CERTIFY, that I attended deceased from Sept 12 to Sept 12, 1939
 I last saw him alive on Sept 7, 1939 Death is said to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:

Apoplexy
 Date of onset _____
 Other contributory causes of importance: g. 2. h.

Name of operation _____ Date of _____
 What test confirmed diagnosis? Symptoms 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 g. 2. h.
 (Signed) _____ M. D.
 (Address) Smithton, 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 important.

1-14223

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 10/10/39

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, _____

L. E. Bouldin

or by _____

Registered Apprentice No. _____, working under my personal supervision.

Signed _____

L. E. Bouldin

Licensed Embalmer No. *3867*

P. O. Address _____

Seaside, 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.