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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registrar's No. 9839

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 791

Primary Registration District No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MARK INK RESERVED FOR BINDING
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. PLACE OF DEATH: 1003
(a) County _____
(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ST. ANTHONYS HOSPITAL
(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)

8. (a) PRINT FULL NAME MINNIE FARRELL 6/1/0
3. (b) If veteran, name war NO
3. (c) Social Security No. NO

4. Sex FEMALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced WIDOW
6. (b) Name of husband or wife DENMAN P. FARRELL
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased JANUARY 11 1865
(Month) (Day) (Year)

8. AGE: Years 74 Months 10 Days 5
If less than one day hr. _____ min. _____

9. Birthplace LEXINGTON MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business HOUSEKEEPER

MOTHER FATHER
12. Name EMANUEL EASTER
13. Birthplace PENN.
(City, town, or county) (State or foreign country)
14. Maiden name REBECCA WURTZ
15. Birthplace PENN.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Ada Williams
(b) Address 5414 Gravois av

17. (a) BURIAL (b) Date thereof NOV 20 39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Sun Set Burial Park

18. (a) Signature of funeral director E. J. Schmur
(b) Address 3125 Lafayette av

19. (a) NOV 18 1939 (b) _____
(Date received local registrar) (Signature of registrar)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County _____
(c) City or town ST. LOUIS 2
(If outside city or town limits, write "RURAL")
(d) Street No. 5414 GRAVOIS AV.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV. day 16th
year 1939 hour 11:20 minute p M.

21. I hereby certify that I attended the deceased from Nov. 6th 1939 to Nov. 16th 1939
that I last saw her alive on Nov. 16th 1939
and that death occurred on the date and hour stated above.

Immediate cause of death
Acute Myocarditis caused by pernicious anemia
Due to _____
Duration 3 da.

Due to 71a
Other conditions Pernicious Anemia 3 Mo
(Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy No.
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) (e) Means of injury _____
While at work _____
23. Signature Dr. W. H. Walters M.D. (M. D. or other)
Address 3608 So. Grand Blvd. Date signed 11/18/39

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, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Joe B. Vollmer

Licensed Embalmer No. *4014*

P. O. Address. *3125 Lafayette Ave.*

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.