

DEC 15 1939
Registration District No. **296**

Primary Registration District No. **4180**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Franklin**
(b) City or town **Union**
(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:

(a) State _____ (b) County _____
(c) City or town _____ (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.

8. (a) PRINT FULL NAME **Missouri Ann Farrell 640**

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

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

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

7. Birth date of deceased **November 30 1860**
(Month) (Day) (Year)

8. AGE: Years **78** Months **II** Days **8** If less than one day _____ hr. _____ min.

9. Birthplace **St. Charles, Missouri.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired House Keeper**

11. Industry or business _____

12. Name **William Murphy**

18. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

14. Maiden name **Paulinia Stump**

15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Mrs. Hattie Bartel**

(b) Address **Union, Missouri.**

17. (a) **Burial** (b) Date thereof **11/10/39**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **New Friendship Cemetery**

18. (a) Signature of funeral director **Wm. H. Horn**

(b) Address **Union, Missouri. 951**

19. (a) **11-10-39** (b) **Lewis H. Housh**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **8**
year **1939** hour **5** minute **30** P. M.

21. I hereby certify that I attended the deceased from **Nov 4** 19**39** to **Nov 8** 19**39**
that I last saw her alive on **Nov 4** 19**39**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Apoplexy 11-3-39**
Arteriosclerosis

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) **g.f.h.**

Major findings: **None**
Of operations _____

Of autopsy **None**

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? _____

While at work _____ (Specify type of place) (c) Means of injury _____

23. Signature **H. H. Matthews** (M. D. or other) _____
Address **Beaufort, Mo** Date signed **11/9/39**

Duration
Physician
Underline the cause to which death should be charged statistically.

MOTHER FATHER

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.

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 W. H. Stone

Licensed Embalmer No. 3175

P. O. Address Union, 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.