FILED MAR 18 1940

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

7827
Do not use this space.

1. PLACE OF DEATH
(a) County Pulaski (b) Registration District No. 713
(b) Township Cuzzen Primary Registration District No. 5942 Registered No.
(c) City (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 620 Amanda Jane Farris
(a) Residence, No. Arcadia St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Wh
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widow
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: George Farris
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): 5/10/1857
7. AGE: YEARS 82 MONTHS 8 DAYS 22 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: Housewife
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:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Missouri
FATHER
13. NAME: Charles Rickerson
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): unknown
MOTHER
15. MAIDEN NAME: unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): unknown
17. INFORMANT (ADDRESS): George Farris Tribune Mo
18. BURIAL, CREMATION, OR REMOVAL PLACE Dry Creek DATE 2/4 1940
19. FUNERAL DIRECTOR (NAME) Fred H. Gillum (ADDRESS) Dixon Mo.
20. FILED 2/12 1940 [signature] Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-2 1940
22. I HEREBY CERTIFY, That I attended deceased from January 28, 1940, to Feb 2, 1940
I last saw her alive on February 3, 1940. 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:

	Date of onset
Heart ailment	
Senility	

Other contributory causes of importance:
Cardiac Asthma

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

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? .....
If so, specify .....
(Signed) DR. K. W. Merrigan M.D.
(Address) Dixon

Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK—THIS IS 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 X14023

Was not Embalmed
Casket made –

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 340 295
Date Filed 3/2/40

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.