

MAY 13 1940

Registration District No. 421

Primary Registration District No. 5590

Registrar's No. 56

1. PLACE OF DEATH:

(a) County Johnson
(b) City or town Columbus
(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) 2
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 65 yrs 3 mo - 22 da (years, months or days)

8. (a) PRINT FULL NAME Lettie L. Farmer

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 married

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

7. Birth date of deceased Dec. 31 - 1874
(Month) (Day) (Year)

8. AGE: Years 65 Months 3 Days 22 If less than one day hr. _____ min. 6

9. Birthplace Johnson Co Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business _____

MOTHER { 12. Name W. C. Davis
13. Birthplace unknown
(City, town, or county) (State or foreign country)

FATHER { 14. Maiden name Annie Wilson
15. Birthplace unknown Ky.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature J. E. Farmer
(b) Address Centerville Mo.

17. (a) Burial (b) Date thereof April 24-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Liberty Cemetery
18. (a) Signature of funeral director Sweetness - Phillips
(b) Address Warrensburg Mo.

19. (a) April 26-40 E. A. Bentley
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illate (b) County Johnson
(c) City or town Centerville Rural
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 23 year 1940 hour 2 minute _____ P. M.

21. I hereby certify that I attended the deceased from about September 37 1940 to April 23 1940, that I last saw her alive on April 17 1940 and that death occurred on the date and hour stated above.

Immediate cause of death: 83 General Paralysis of the Insane - ✓ Duration 10 days

Due to _____
Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations NONE Of autopsy NONE
PHYSICIAN _____ Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: NONE

(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? 301

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

23. Signature E. R. Cooper MD (M. D. or other) _____
Address Warrensburg Mo Date signed 4-24-40

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

19381

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.

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RECORDED
INDEXED
MAY 1940

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 5-9-40

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.....

R. W. Phillips

Registered Apprentice No.....

working under my personal supervision.

Signed *R. W. Phillips*

Licensed Embalmer No. *2320*

P. O. Address *Warrensburg, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 15262

Registration District No. 431

Primary Registration District No. 5390

Registrar's No. 56

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

1. PLACE OF DEATH:

(a) County Johnson

(b) City or town Columbus T.P.
(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 years, months or days)

3. (a) PRINT FULL NAME Lottie K. Farmer

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive

7. Birth date of deceased (Month) (Day) (Year)

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

65 3 22 hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name

{ 13. Birthplace (City, town, or county) (State or foreign country)

{ 14. Maiden name

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

16. (a) Informant (b) Address

17. (a) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director (b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Apr day 23 year 1990 hour minute M.

21. I hereby certify that I attended the deceased from that I last saw him alive on and that death occurred on the date and hour stated above.

Immediate cause of death 83 General paresis of the insane Duration 1-2 years

Due to Senile paresis

Due to

Other conditions (Include pregnancy within 3 months of death) 1/62

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) (e) Means of injury

23. Signature E. P. Cooper (M. D. or other) Address Wrensburg Date signed kw

SUPPLEMENTAL 1990

