

Registration District No.

Primary Registration District No. 1003

1. PLACE OF DEATH:

(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: Christian Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution Hospital
 (Specify whether
 In this community 5 days
 years, months or days)

3. (a) PRINT FULL NAME Barbara Ann Farrell 640

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

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

7. Birth date of deceased May 8 1940
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 5 hr. min.

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

10. Usual occupation None

11. Industry or business _____

12. Name Frank Farrell

13. Birthplace St. Louis Mo.
 (City, town, or county) (State or foreign country)

14. Maiden name Edna May Richter

15. Birthplace St. Louis Mo.
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Frank Farrell

(b) Address 4502 Adelaide Ave.

17. (a) Burial (b) Date thereof May 13 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine

18. (a) Signature of funeral director Charles W. Thomas

(b) Address 4911 Washington Pl.

19. (a) MAY 13 1940
 (Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St. Louis 502 Adelaide Ave.
 (If outside city or town limits, write "RURAL")
 (d) Street No. 4502 Adelaide Ave.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 13
 year 1940 hour 1 minute 10 M.

21. I hereby certify that I attended the deceased from May 8, 1940 to May 13, 1940
 that I last saw her alive on May 13, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Respiratory paralysis

Due to Medullary hemorrhage

Due to _____

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

Major findings: Of operations no

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature J. E. Harris (M. D. or other) MD

Address 4505 W. Filament Date signed 5-13-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

FORM 1 X1981

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. *Not embalmed*

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.