

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **20357**

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **5305**

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

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

3. (a) PRINT FULL NAME **Genevieve P. Farrar** **660**

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 **Single**

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

7. Birth date of deceased **May 12 1940**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	0	1	6	hr. _____ min. _____

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

10. Usual occupation **Nil.**

11. Industry or business **Nil.**

12. Name **Elmer John Farrar**

13. Birthplace **Cape Girardeau Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **Hazel Genevieve Hale**

15. Birthplace **St. Genevieve Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Elmer J. Farrar**

(b) Address **522 Graf Ave. Ferguson Mo.**

17. (a) **Burial** (b) Date thereof **6 20 40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary**

18. (a) Signature of funeral director **Walter Kelly**
(b) Address **7267 Natural Bridge**

19. (a) **JUN 19 1940** (b) **J. F. Brodek**
(Date of issue) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(c) City or town **Ferguson** **N.R.**
(If outside city or town limits write "RURAL")
(d) Street No. **522 Graf Ave.**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **18**
year **1940** hour **6** minute **40** P. M.

21. I hereby certify that I attended the deceased from **JUNE 13**, 19**40**, to **JUNE 18**, 19**40**
that I last saw her alive on **June 18**, 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death: **dehydration Malnutrition**

Due to **Congenital malformation of hard palate (cleft)**

Other conditions (Include pregnancy within 3 months of death) **None**

Major findings: Of operations _____
Of autopsy **no**

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) _____
While at work _____ (2) Means of injury _____
23. Signature **Walter Kelly** (M. D. or other) _____
Address **3720 Washington**

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

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

Robert McNeary

Licensed Embalmer No. *3732*

P. O. Address *St. Louis*

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.