

S. No. 2
-11-10-39
5-17-39
P-I X21492

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **20784**
Registrar's No. **2401**

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2805 Park Avenue
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ---
(Specify whether
In this community 25 Years
years, months or days)

3. (a) PRINT FULL NAME Mr. Monroe Frank Farris 620
(b) If veteran, name war None
(c) Social Security No. None

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Mrs. Katie Farris
6. (c) Age of husband or wife if alive --- years
7. Birth date of deceased May 22 1857
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
83 0 19 hr. min.

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

10. Usual occupation Farmer

11. Industry or business ---

12. Name Thomas L. Farris
13. Birthplace Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Nancy McClure
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant M. F. Farris
(b) Address 2236 Norton

17. (a) Burial (b) Date thereof June 13, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation 1111 Memorial Park Cem.

18. (a) Signature of funeral director H. H. McCamers' Sons
(b) Address 1401 Brush Creek Blvd.

19. (a) June 12, 1940 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 2805 Park Avenue
(If rural, give location)
(e) If foreign born, how long in U. S. A.? --- years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day 10th
year 1940 hour 6 minute 15 P. M.

21. I hereby certify that I attended the deceased from _____, 19____ to _____, 19____;
that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death
Chronic Myocardial Infarction
Due to
Coronary Atherosclerosis
Due to
9412

Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

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
28. Signature Russell W. Jones (M. D. or other)
Address St. Louis Date signed 6/11/40

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

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

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 Emile M. Calhoun

Licensed Embalmer No. 3506

P. O. Address Fe 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.