

Registration District No. 791

Primary Registration District No. 1003

PLACE OF DEATH: St. Louis, Mo.

(a) County.....
(b) City or town.....
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Sanitarium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 mo. 3 days.
(Specify whether
In this community 33 years
years, months or days)

3. (a) PRINT FULL NAME LEONARD FARLEY

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

4. Sex Male 5. Color or race Col 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Martha Farley 6. (c) Age of husband or wife if alive years
7. Birth date of deceased About 1868
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
About 72 hr. min.

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

10. Usual occupation Janitor

11. Industry or business Apartment House

12. Name Frank Farley

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

14. Maiden name Charity

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

16. (a) Informant John Ladd

(b) Address 5409 Grand

17. (a) Burial (b) Date thereof Oct 16, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood

18. (a) Signature of funeral director C. W. Roberts

(b) Address 3035 Lucas Ave

19. (a) OCT 15 1940 (b) John Ladd
(Date of local burial) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County.....
(c) City or town St. Louis 13
(If outside city or town limits, write "RURAL")
(d) Street No. City Infirmary
(If rural, give location)
(e) If foreign born, how long in U. S. A. years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 8
year 1940 hour 5:30 minute A. M.

21. I hereby certify that I attended the deceased from Mar. 6, 1940
19 to Oct. 7 19 40
that I last saw him alive on Oct. 7, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis 3-6-40X

Due to Generalized Arteriosclerosis
3-6-40-x

Due to.....

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

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?.....

While at work? (Specify place of place) Means of injury.....

23. Signature Th. H. H. H. H. H. (Signature of physician or other)

Address 5409 Grand Date signed.....

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 me

Chas. Gaines, Registered Apprentice No. 2349
working under my personal supervision.

Signed

Chas. Gaines

Licensed Embalmer No. 2349

P. O. Address _____

OK
Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.** (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.