

0. 2
13-40
7-39
X23159

Registration District No. **7917**

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:
St. John's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days) **/**

2. USUAL RESIDENCE OF DECEASED:

(a) State..... **Illinois** (b) County.....
(c) City or town..... **Ashley**
(If outside city or town limits, write "RURAL") **N.I.R**
(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 **12** day **31**
year **1940** hour **3:50** minute **A** M.

21. I hereby certify that I attended the deceased from
12-23- 19**40**, to **12-31-** 19**40**
that I last saw him alive on **12-31-** 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Coronary Thrombosis
Due to **Arterio Sclerotic Heart Disease**
Due to.....

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy.....

Duration
PHYSICIAN
Underline
the cause to
which death
should be
charged sta-
tistically.

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 (a) Means of injury.....
23. Signature **Carl J. Kreis** (M. D. or other)
Address **3604 Washington** Date signed **12-31-40**

3. (a) PRINT FULL NAME **Charles Henry Farmer**

3. (b) If veteran, name war **No.** 3. (c) Social Security No. **337-18-8148**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Ida Armita** 6. (c) Age of husband or wife if alive **67** years
7. Birth date of deceased **March 30 1871**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 9 1 hr. min.

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

10. Usual occupation **Mgr. Lumber Yard**

11. Industry or business

12. Name **John Farmer**

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

14. Maiden name **Martha Meyers**

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

16. (a) Informant **Mrs. Mamie Hall**

(b) Address **Anna, Illinois**

17. (a) **Removal** (b) Date thereof **12/31/40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Ashley, Ill.**

18. (a) Signature of funeral director **Albert H. Hoppe**

(b) Address **4700 Washington Ave.**

19. (a) **DEC 31 1940** (b) **J. W. Budeck**
(Date received local registrar) (Registrar's signature)

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

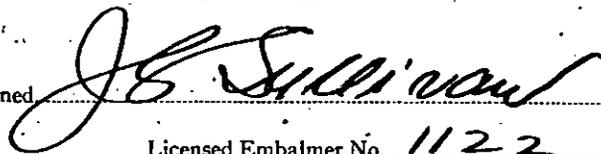
STATEMENT BY LICENSED EMBALMER

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



Licensed Embalmer No. 1122

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, fact should be so stated above.