

FILED MAY 15 1941

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space

15647

1. PLACE OF DEATH

(a) County Ray Registration District No. 739
 (b) Township Cambden Primary Registration District No. 5974
 (c) City Cambden (d) Street No. 1
 (If death occurred in Hospital or Institution, write name instead of street and number)
 (Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if foreign birth? yrs. mos. ds.)

2. PRINT FULL NAME William A Farmer

(a) Residence, No. _____ St. (If no street address, write county or city)
 (Usual place of abode, if no street address, write county or city) St. (If no resident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widower 2
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Widower
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 8/30/1857
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
81 7 2
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Blacksmith
 9. Industry or business in which work was done, as saw mill, bank, etc. in mine work
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY AND YEAR) 4/2 1939
 22. I HEREBY CERTIFY, That I attended deceased from Oct. 2 1938 to April 2 1939
 I last saw him alive on April 1 1939. Death is said to have occurred on the date stated above, at 1 P. m.
 The principal cause of death and related causes of importance were as follows:

Cerebral arteriosclerotic psychosis
Arteriosclerotic heart disease
(Coronary myocarditis)
 Date of onset Dec. 1

Other contributory causes of importance:

Post operative
fracture
 Name of operation hemorrhoid proctotomy Date of _____
 What test confirmed diagnosis? PC Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? No Date of injury _____, 19____
 Where did injury occur? No
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury None
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____
 (Signed) W. Campbell M. D.
 (Address) Quick, Mo.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) North Carolina
 FATHER 13. NAME Benjamin Farmer
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) North Carolina
 MOTHER 15. MAIDEN NAME Mary Rominger
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn.
 17. INFORMANT Mrs. Mary Elliott
 (ADDRESS) Smith Mo
 18. BURIAL, CREMATION, OR REMOVAL
 PLACE Crown Creek DATE 4/3 1939
 19. FUNERAL DIRECTOR C. H. Brown
 (ADDRESS) Smith Mo
 20. FILED 5/10/41 W. Campbell
 Local Registrar.

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.

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RECEIVED

District Health Officer No. 8,

District Number _____

Date Filed 5-13-41

STATEMENT BY LICENSED EMBALMER

I, W. Gibson, Licensed Embalmer No. 2299

hereby certify that the body recorded on the reverse side of this certificate was embalmed by Edward C. Gibson

_____ L. E. _____

No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed W. Gibson

Licensed Embalmer No. 2299

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.)

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15647

Registration District No. 739

Primary Registration District No. 5974

Registrar's No. _____

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

ROWENA MOORE
AGENT RECEIVED

1. PLACE OF BIRTH:

(a) County Ray
(b) City or town Camden Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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)

3. (a) PRINT FULL NAME Wm A. Farmer
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w
6. (a) Single, widowed, married, divorced wid
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year _____ month _____ day _____

7. Birth date of deceased (Month) _____ (Day) _____ (Year) _____

8. AGE: Years 81 Months 7 Days 2 If less than one day _____ hr _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof (Month) _____ (Day) _____ (Year) _____

(Burial, cremation, or removal) _____ (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) 6/2/41 (b) W. Campbell, MD

(Date received local registrar) _____ (Registrar's signature) _____

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Month 4 day 2 year 1939 minute _____ 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 Cerebral arteriosclerosis arteriosclerotic heart disease Chronic myocarditis post-operative prostatic hypertrophy transurethral prostatectomy

Due to _____ (Specify type of place) _____ (e) Means of injury _____

Other conditions (Include pregnancy within 9 months of death) _____

Major findings: prostatectomy transurethral prostatectomy Nov. 1938

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? _____

23. Signature W. Campbell (M. D. or other) MD
Address _____ Date signed _____

PHYSICIAN

Underline the disease to which death should be charged statistically.

SUPPLEMENTARY

S-15647