DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 4014

FILED FEB 11 1942

Registration District No. 903 Primary Registration District No. 6212 Registrar's No.

113
C
O

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

1. PLACE OF DEATH:
(a) County Worth
(b) City or town Rural Mitchell Tp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Grant City
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether)
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Worth
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Grant City Mo.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 65 years.

3. (a) PRINT FULL NAME EDITH ALICE FARNSWORTH

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ed Farnsworth

6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased July (Month) 7 (Day) 1876 (Year)

8. AGE: Years 65 Months 6 Days 5 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER
12. Name Joseph Waughy
13. Birthplace (City, town, or county) Indiana (State or foreign country)
14. Maiden name Nancy Angeline Griffin
15. Birthplace (City, town, or county) Indiana (State or foreign country)

16. (a) Informant Ed Farnsworth
(b) Address Grant City, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 13, 1942 (Month) (Day) (Year)
(c) Place: burial or cremation Haven Grove

18. (a) Signature of funeral director Joseph C. Dunfee
(b) Address Grant City, Mo.

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day Swelth
year 1942 hour Three minute A.M.

21. I hereby certify that I attended the deceased from Jan 1st, 1942 to January 12, 1942
that I last saw her alive on January 10 th, 1942
and that death occurred on the date and hour stated above.

| Immediate cause of death | Duration |
|---|---|
| Hemorage from Stomach | 2 Hrs |
| Due to Arterio Sclerotic Heart Disease | One Yr |
| Due to Diabetis Melitis | 20 Yr |
| Other conditions (Include pregnancy within 3 months of death) | |

Major findings:
Of operations 10
Of autopsy

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

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? (e) Means of injury

23. Signature O. L. Faulkner (M. D. or other)
Address Redding Iowa Date signed

(Licensed Embalmer's Statement on Reverse Side)

## 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 Arch C. Dunfee

Licensed Embalmer No. 3252

P. O. Address Grant City 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.**

V. S. No. 2B
10M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 41014

Registration District No. 903 Primary Registration District No. 6212 Registrar's No.

**1. PLACE OF DEATH:**
(a) County: Worth
(b) City or town: Rural
(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 years, months or days) In this community

**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

3. (a) PRINT FULL NAME: Edith A. Farnsworth
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive Years
7. Birth date of deceased: July (Month) 7 (Day) 1876 (Year)
8. AGE: Years 65 Months 6 Days If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) Jan 29, 1942 (Date received local registrar) (b) Arlene Sullens (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Jan Day 11 year 1942 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.

| Immediate cause of death | Duration |
|---|---|
| Due to | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |
| Major findings: Of operations | |
| Of autopsy | |

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

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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY