S. No. 2
M—S-42
5-17-39
I X32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 28 1942

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

31922

State File No.

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8624

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

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Little Sisters of the poor 5
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 months (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED: 000
(a) State Missouri (b) County 17
(c) City or town St. Louis, 920
(If outside city or town limits, write "RURAL")
(d) Street No. 3225 N Florissant Ave.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Thomas H. Farnen
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Male 0
5. Color or race White
6. (a) Single, widowed, married, divorced 9
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased August (Month) 22 (Day) 1865 (Year)
8. AGE: Years 77 Months 1 Days 24 If less than one day hr. min.
9. Birthplace (City, town, or county) 9 (State or foreign country)
10. Usual occupation Laborer
11. Industry or business
FATHER
12. Name William Farnen
13. Birthplace Ireland (City, town, or county) 4 (State or foreign country)
MOTHER
14. Maiden name Mary Moore
15. Birthplace Ireland (City, town, or county) 4 (State or foreign country)
16. (a) Informant Clarence Farnen
(b) Address 4589 Kennerly Ave.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 (Month) 19 (Day) 1942 (Year)
(c) Place: burial or cremation Calvary
18. (a) Signature of funeral director Sullivan Undertaker
(b) Address 2849 N. Euclid Ave.
19. (a) OCT 17 1942 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 16
year 1942 hour 4 P.M. minute M.
21. I hereby certify that I attended the deceased from Sept. 15, 1942 to Oct. 16, 1942
that I last saw him alive on Oct. 16, 1942
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic Myocarditis	
Due to Arteriosclerosis	
Due to	
Other conditions Bronchial Asthma (Include pregnancy within 3 months of death)	

Major findings:
Of operations 9 30
Of autopsy 9 30

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 0
23. Signature Anthony A. Chekovski (M. D. or other) M.D.
Address 1525a Cass Ave Date signed 10/17/42

(Licensed Embalmer's Statement on Reverse Side)

Dr. Anthony A. Piekarski
1525a Cass Ave.
CE 4409

Between 10 & 11 am

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 Albert Mayfield

Licensed Embalmer No. 3077

P. O. Address St Louis Mo

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

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

V. S. No. 2B
0M—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. 31922

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8624

1. PLACE OF DEATH:

(a) County
(b) City or town St Louis, Mo.
(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 Thomas H. Farnen
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 Widowed
6. (b) Name of husband or wife Alice Murphy
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Aug (Month) 22 (Day) 1864 (Year)
8. AGE: Years 77 Months 1 Days If less than one day 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) NOV 27 1942 (Date received local registrar) (b) J. T. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct Day 26 year 1942 hour 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.

	Duration
Immediate cause of death	
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