

1818
S. No. 2
4-9-441
5-17-39
I X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **12109**
Registrar's No. **3811**

REC MAY 3 1943 818
Registration District No. _____
Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 Days**
(Specify whether
In this community **life**
years, months or days)

3. (a) PRINT FULL NAME **Joseph George Farrell**
(b) If veteran, name war _____ (c) Social Security No. _____

4. Sex **MA** 5. Color or Race **W** 6. (a) Single, widowed, married, divorced **single**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years (Day) (Year)

7. Birth date of deceased **March 1 1909**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
34 **1** **23** hr. min.

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

10. Usual occupation _____

11. Industry or business **Unemployed**

12. Name **Joseph**
13. Birthplace **Mo.** (City, town, or county) (State or foreign country)

14. Maiden name **Julia Milward**
15. Birthplace **unknown** (City, town, or county) (State or foreign country)

16. (a) Informant **Martha Decker**
(b) Address **2830 Cherokee**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **4/24/43**
(Month) (Day) (Year)

(c) Place: burial or cremation **St. Matthews**
18. (a) Signature of funeral director **W. M. Laughlin**
(b) Address **2301 Lafayette**

19. (a) **APR 21 1943** (Date received local registrar) **J. B. Bruback** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **000 19**
(c) City or town **St. Louis** **9 V 3**
(If outside city or town limits, write "RURAL")
(d) Street No. **1047 Geyer** (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **April** day **23**, year **1943** hour **11:00** minute _____ A. M.

21. I hereby certify that I attended the deceased from **April 21**, 19 **43** to **April 23**, 19 **43** that I last saw him alive on **April 23**, 19 **43** and that death occurred on the date and hour stated above.

Duration _____
Immediate cause of death **Melaninemia & Acetaminosis**
hypertension
Due to **HT disease, etiology undetermined**
Due to **hypertension heart**
Other conditions (include pregnancy within 3 months of death) **93d**

PHYSICIAN _____
Major findings: Of operations _____
Of autopsy **as above**
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? _____
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature **Dwight Belser** (M. D. or other) **4/23/43**
Address **1515 Lafayette Avenue** Date signed _____

not Embalmed

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 *L. Cooper*.....

Licensed Embalmer No. *3633*

P. O. Address *2317 Lafayette*

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.