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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

15 AUG 9 1943

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25702

State File No. _____

Registration District No. 267

Primary Registration District No. 5900

Registrar's No. 38

1. PLACE OF DEATH:

(a) County Missouri

(b) City or town Deering Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1 Barrack St. Deering
(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 Missouri (b) County Missouri

(c) City or town rural
(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 Hollie Bester Farris

3. (b) If veteran, name war No

3. (c) Social Security No. NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 4
year 1943 hour 2:00 minute P M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife none

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

7. Birth date of deceased August 15 1935
(Month) (Day) (Year)

that I last saw h. _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death trauma (July 4 accident)

Due to _____

Due to _____

8. AGE:

Years	Months	Days	If less than one day
<u>10</u>	<u>10</u>	<u>19</u>	hr. _____ min.

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.

9. Birthplace Johnston County Arkansas
(City, town, or county) (State or foreign country)

10. Usual occupation Child

11. Industry or business none

MOTHER FATHER

12. Name Hollace Farris

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

14. Maiden name Deaton

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

16. (a) Informant Hollace Farris

(b) Address St. Louis, Mo. Apt #2

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof July 5 1943
(Month) (Day) (Year)

(c) Place: burial or cremation St. Louis, Mo. Mt Zion Cemetery

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) V078

(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 ✓

18. (a) Signature of funeral director German Hall Co

(b) Address St. Louis, Mo. Apt #2

19. (a) 7-14-43
(Date received local registrar)

(b) George Burkhardt
(Registrar's signature)

23. Signature Hollie Farris (M. D. or other) 0

Address St. Louis, Mo Date signed 7-21-43

UNFADING BLACK INK—MAKE A PERMANENT RECORD

743-260

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.....

John H. German....., Registered Apprentice No. *344*
working under my personal supervision.

Signed *J. R. Stonor*
Licensed Embalmer No. *3100*
P. O. Address *Blytheville*

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

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

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

AUG 10 1943
State File No. _____
Registrar's No. 38

Registration District No. 267

Primary Registration District No. 0900

1. PLACE OF DEATH:

(a) County Pemiscot
(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

In this community _____ years, months or days) (Specify whether

3. (a) PRINT FULL NAME Helle Lester James

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 6

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

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

8. AGE: Years 10 Months 1 Days 10 If less than one day _____ 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) _____ (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) _____ (Date received local registrar) (b) _____ (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 _____ year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death: drowned 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) Accident

(b) Date of occurrence July 4 1943

(c) Where did injury occur Public Place (City or town) _____ (County) _____ (State) _____

(d) Did injury occur in or about home, on a farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury drowned

23. Signature W. Shiner (M. D. or other) M.D.

Address Hayti, Mo. Date signed 8-13-43

WRITE PLAIN INK--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

SUPPLEMENTARY

S 25702