

FILED SEP 11 1943

Registration District No. _____

Primary Registration District No. 1001

Registrar's No. 934

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

1. PLACE OF DEATH:

(a) County BUCHANAN
(b) City or town ST. JOSEPH
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital # 2 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution SINCE JUNE 14 1938
In this community 5 years 2 mths 8 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
(d) Street No. State Hosp. #2.
(If rural, give location)
(e) Citizen of foreign country? U.S.A. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 22 1943
year 1943 hour 60 minute 15 P.M.
21. I hereby certify that I attended the deceased from Aug. 10,
10th. 1943, to Aug. 22 1943
that I last saw him alive on Aug. 22 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumo-pneumonia Duration
and myocarditis

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) 934

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)
(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 Michael B. Schaff (M.D. or other) MD
Address State Hosp. #2 Date signed 8/23/43

3. (a) PRINT FULL NAME HOMER FERRELL

3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex MALE 5. Color or race White 6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife RUTH FARRELL (WIFE) 6. (c) Age of husband or wife if alive 18 years (Month) (Day) (Year)
7. Birth date of deceased Jan. 18 1887 (Month) (Day) (Year)

8. AGE: Years 56 Months 7 Days 4 If less than one day hr. min.

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

10. Usual occupation Farming.

11. Industry or business Farming.

MOTHER FATHER { 12. Name Andrew J. Farrell
13. Birthplace Mo. (City, town, or county) (State or foreign country)
14. Maiden name Jennie Doucson
15. Birthplace Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Ruth Farrell
(b) Address Faucett Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/43 (Month) (Day) (Year)

(c) Place: burial or cremation Halleck Mo.

18. (a) Signature of funeral director Deaton B. Baker & Bowman
(b) Address 319 So. 10th

19. (a) 8/24/43 (Date received local registrar) (b) Rose Hazy (Registrar's signature)

1 1233

St Joseph, Mo.

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

Frank A. Bowman

Licensed Embalmer No. 1710

P. O. Address St. Joseph 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, fact should be so stated above.