

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31971

State File No.

Registration District No. 174

Primary Registration District No. 3035

Registrar's No. 70

1. PLACE OF DEATH:

(a) County Lafayette
(b) City or town Luxington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution 17th Poplar
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lafayette
(c) City or town Luxington 054
(If outside city or town limits, write "RURAL")
(d) Street No. 17th Poplar
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____ 1

3. (a) PRINT FULL NAME HARVEY FARRELL

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

4. Sex M.A. 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mattie P. Benton 6. (c) Age of husband or wife if alive 80 years

7. Birth date of deceased Aug 6 1861
(Month) (Day) (Year)

8. AGE: Years 82 Months 1 Days 18 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farm

11. Industry or business Retired

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 Mrs. Mattie Benton

(b) Address Luxington, Mo

17. (a) Burial (b) Date thereof Sept 26-1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation South Higginsville

18. (a) Signature of funeral director Winkler

(b) Address Luxington, Mo

19. (a) Oct-6-43 (b) Mrs. G. Schwal
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 24
year 1943 hour 1 minute 9 M.

21. I hereby certify that I attended the deceased from Sept 9th 1943 to Sept 24 1943
that I last saw him alive on Sept 23rd 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary failure myocard

Due to Chronic dilatated
myocard

Due to Chronic coronary
arteriosclerosis

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 13/a
Of autopsy _____

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 O.P. Kegan (M. D. or other) _____
Address Luxington Mo Date signed 10/4/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

RECEIVED
District Health Officer No. 8,
Date Filed 10-11-43

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 *Forrest G. Simpson*
Licensed Embalmer No. *3275*
P. O. Address *Higginston, Va.*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Oct.

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF BIRTH:

(a) County Lesayette
 (b) City or town Shelbington
(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 9 yr. (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Harvey Farrell
 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 m
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Aug. 6 (Month) (Day) (Year)

8. AGE: Years 82 Months 1 Days _____ Unless than one day _____ min.

9. Birthplace Lesayette, Missouri (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) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) Oct 6 1943 (b) Mrs. Fred Schwal
(Date received local registrar) (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 Sept day 24 year 1943 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____
 Due to _____

Other conditions _____ (include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____

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 _____ (M. D. or other) _____
 Address _____ Date signed _____

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

SUPPLEMENTARY

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

31971