

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSSTATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

NOV 18 1943

Registration District No. 326

Primary Registration District No. 6104

Registrar's No. 40

1. PLACE OF DEATH:

(a) County Scotland
 (b) City or town Downing Rural
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1 Miller, Miss
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community Entire Life years, months or days)

3. (a) PRINT FULL NAME Alfred U Farnsworth
 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 Lida C Farnsworth 6. (c) Age of husband or wife if alive 65 years
 7. Birth date of deceased Mar 15 1874
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 6 2 hr. min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name Alfred H. Farnsworth

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

14. Maiden name Ruth C Cox

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

16. (a) Informant Mrs Lida Farnsworth

(b) Address Downing Mo

17. (a) Burial (b) Date thereof 4th 20 1943
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation buried

18. (a) Signature of funeral director Arthur Bassett

(b) Address Memphis Mo

19. (a) Oct 31 1943 (b) Bessie Wilson
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Scotland
 (c) City or town Downing 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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 18
 year 43 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 22 Sept 43 to 18 Sept 43
 that I last saw him alive on Sept 6 1943
 and that death occurred on the date and hour stated above.

Immediate cause of death Myeloid leukemia ✓ Duration 2 yrs.

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) (c) Means of injury _____

23. Signature E E Hillman (M. D. or other) Mo

Address Memphis, Mo Date signed 9-26-43

RECEIVED
District Health Officer No. 10
District File Number 11-43-1831
Date filed NOV 15 1943

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 *Fred Gustafson*
Licensed Embalmer No. *4256*
P. O. Address *Memphis, Tenn.*

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. Dec

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

1. PLACE OF DEATH:
 (a) County Scottland
 (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
 years, months or days)

3. (a) PRINT FULL NAME Alfred U. Farnsworth
 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 65 year

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

8. AGE: Years 69 Months 6 Days 5 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 Sept year 1943 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 Melanoma of face and metastases to lungs.

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 _____

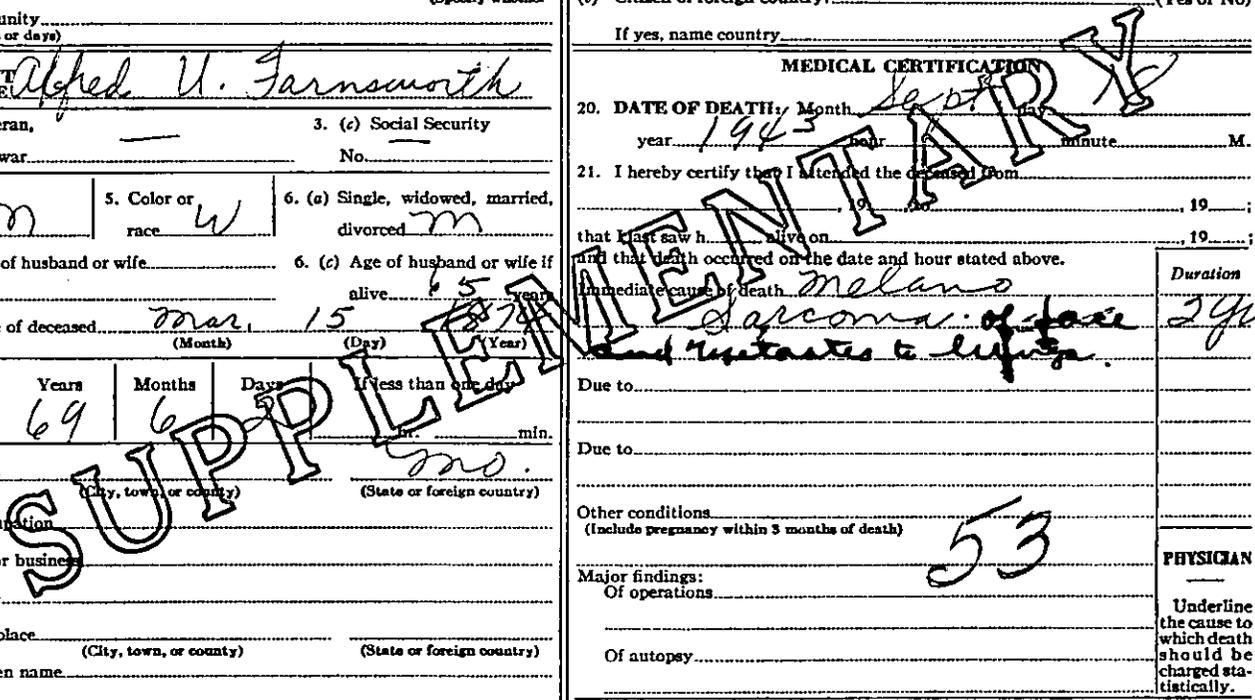
(c) Where did injury occur? _____ (City or town) (County) (State)

(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 E. E. O. O. O. (M. D. or other) Yeh
 Address Memphis, Tenn Date signed 11-26-43

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



MOTHER FATHER

Duration _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

S-39295