

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

HOPE 7529  
State File No.

FILED FEB 24 1944  
Registration District No. 170

Primary Registration District No. 3033

Registrar's No.

53  
1  
2

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

1. PLACE OF DEATH:

(a) County LAC LADE

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

(c) Name of hospital or institution:  
WALLACE HOSPITAL  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 DAYS (Specify whether years, months or days)

In this community 10 YRS (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County LAC LADE

(c) City or town RURAL  
(If outside city or town limits, write "RURAL")

(d) Street No. FALCON  
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME LILLIAN J. FARLOW

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 10  
year 1944 hour 10 minute 50 A.M.

21. I hereby certify that I attended the deceased from 1/3  
\_\_\_\_\_ 1944 to 1/10 1944  
that I last saw her alive on Jan 10, 1944  
and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife CHARLES FARLOW 6. (c) Age of husband or wife if alive 77 years

7. Birth date of deceased JUN 4 1904  
(Month) (Day) (Year)

Immediate cause of death myocardial failure Duration 7 days

8. AGE: Years 39 Months 6 Days 6 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to malnutrition ?

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

Due to dementia 2 or 3 yrs?

10. Usual occupation HOUSE WIFE

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name W. H. GOLDMAN

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

14. Maiden name MANDY BANTON

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

Major findings: Of operations \_\_\_\_\_ Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Charles Farlow

(b) Address Falcon, Missouri

17. (a) BURIAL (b) Date thereof 1-12-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation NEW HOME CEM.

18. (a) Signature of funeral director PALMER'S

(b) Address LEBANON MO

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? \_\_\_\_\_

19. (a) 1-31-44 (b) Grace Roper  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) (a) Means of injury \_\_\_\_\_

23. Signature Jeanne L. Hooper (M. D. or other) \_\_\_\_\_  
Address Lebanon Mo Date signed 1/13/44

1090

Received.....

Laclede County Health Unit

File No. 1-44-4

Date Filed 2/21/47

**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 Allyn Wethers

Licensed Embalmer No. 14333

P. O. Address Libanon 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.**