S. No. 2
OM—2-43
v. 5-17-39
I X35897

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 20 1944

Registration District No. 93

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5336

State File No. 37578

Registrar's No. 54

1. PLACE OF DEATH:
(a) County: DADE
(b) City or town: Rural · CENTER Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 5 Mi. E. of GREENFIELD
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: No (Specify whether)
In this community: 75 years
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: MISSOURI (b) County: DADE
(c) City or town: RURAL
(If outside city or town limits, write "RURAL")
(d) Street No.: 5 Mi. E. of GREENFIELD
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: No

3. (a) PRINT FULL NAME: S. GENEVRA FARRIER
3. (b) If veteran, name war: No
3. (c) Social Security No.: NO
4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: WIDOW
6. (b) Name of husband or wife: C. H. FARRIER
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: MAY (Month) 22 (Day) 1869 (Year)
8. AGE: Years 75 Months 3 Days 9 If less than one day hr. min.
9. Birthplace: DADE Co. (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: HOME
11. Industry or business: " "
MOTHER FATHER
12. Name: FRANKLIN STOCKTON
13. Birthplace: No RECORD (City, town, or county) (State or foreign country)
14. Maiden name: MARY BEALS
15. Birthplace: No RECORD (City, town, or county) (State or foreign country)
16. (a) Informant: Leon Farrier
(b) Address: Greenfield Mo
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9-3-44 (Month) (Day) (Year)
(c) Place: burial or cremation: GREENFIELD
18. (a) Signature of funeral director: Ward Funeral Home
(b) Address: Greenfield Mo.
19. (a) Sept 2/44 (Date received by registrar) (b) Phyllis Lack (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPTEMBER day 1 year 1944 hour 9 minute 30 A. M.
21. I hereby certify that I attended the deceased from 8-1-44, 19__, to 9-1, 1944 that I last saw her alive on 8-27, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cardio-vascular-renal disease	
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):
(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: H. O'Conran (M. D. or other)
Address: Greenfield Mo Date signed 9-2-44

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6
District File Number 1144-1140
Date Filed NOV 14 1944

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 Sam E. Sensenney Jr.

Licensed Embalmer No. 4099

P. O. Address Greenfield 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.