. No. 2
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5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 12 1945

Registration District No. 1

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6913

Primary Registration District No. 4433

Registrar's No. 7

1. PLACE OF DEATH:

(a) County: Putnam

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

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

(d) Length of stay: In hospital or institution 13 days (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Putnam

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

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

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Willard E. 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: Nellie A. Farnsworth

6. (c) Age of husband or wife if alive: 66 years

7. Birth date of deceased: May (Month) 8 (Day) 1873 (Year)

8. AGE:

Years	Months	Days	If less than one day
71	8	11	hr. min.

9. Birthplace: Warsaw (Wayne Co.) Iowa (City, town, or county) (State or foreign country)

10. Usual occupation: Carpenter

11. Industry or business: Carpenter

MOTHER FATHER

12. Name: G. H. Farnsworth

13. Birthplace: West Virginia (City, town, or county) (State or foreign country)

14. Maiden name: Elizabeth Brown

15. Birthplace: Wayne Co., Iowa (City, town, or county) (State or foreign country)

16. (a) Informant: Nellie A. Farnsworth

(b) Address: Powersville, Missouri

17. (a) ~~Place of~~ BURIAL (Burial, cremation, or removal) (b) Date thereof: JAN-23-1945 (Month) (Day) (Year)

(c) Place: burial or cremation: Powersville Cemetery

18. (a) Signature of funeral director: Comstock Funeral Home

(b) Address: Unionville, Mo. By John N. Comstock

19. (a) FEB-15-45 (Date received local registrar) (b) [illegible] (Registrar)

1899

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JANUARY day 19 year 1945 hour 6 minute 15 P.M.

21. I hereby certify that I attended the deceased from Dec 20 1944 to Jan 19 1945 that I last saw him alive on Jan 19 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Acute uremia

Due to: Chronic prostatitis

Due to:

Other conditions (Include pregnancy within 3 months of death):

Major findings: Of operations: 3 7 6

Of autopsy:

Duration

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: L. W. McDonald (M. D. or other) MD

Address: Unionville, Mo. Date signed 1/22/45

RECEIVED
District Health Officer No. 10
District File Number 3-45-463
Date Filed MAR 8 1945

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 John N. Comstock

Licensed Embalmer No. 3891

P. O. Address Unionville, 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.