S. No. 2
M—2-43
. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 6 1945

Registration District No. 179

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 10093

Primary Registration District No. 4287

Registrar's No.

1. PLACE OF DEATH:
(a) County: Lincoln
(b) City or town: Troy
(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)
In this community: 1 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Lincoln
(c) City or town: Troy
(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

3. (a) PRINT FULL NAME: JAMES JACKSON FARMER
3. (b) If veteran, name war: None
3. (c) Social Security No.: None
4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: W
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: Aug (Month) 17 (Day) 1881 (Year)
8. AGE: Years 63 Months 3 Days 16 If less than one day hr. min.
9. Birthplace: (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: Retired
11. Industry or business:
FATHER
12. Name: John Farmer
13. Birthplace: (City, town, or county) Missouri (State or foreign country)
MOTHER
14. Maiden name: Unknown
15. Birthplace: (City, town, or county) Missouri (State or foreign country)
16. (a) Informant: Orle Farmer
(b) Address: Troy Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-7-45 (Month) (Day) (Year)
(c) Place: burial or cremation: Warrenton Mo.
18. (a) Signature of funeral director: Wayne McCoy
(b) Address: Troy Mo.
19. (a) March 8, 1945 (Date received local registrar) (b) Paul Gillon (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 5 year 1945 hour 2 minute 45 P. M.
21. I hereby certify that I attended the deceased from 10/2, 1944 to 3/5, 1945 that I last saw him alive on Mar 5, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Apoplexy	5 hrs
Due to: Arteriosclerosis	
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: J. O. O. Veach MD (M. D. or other)
Address: Troy Mo Date signed 3/9/45

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 4-5-45

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 Wayne McCoy
Licensed Embalmer No. 3586
P. O. Address Troy 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.