. S. No. 2
DM—8-43
v. 5-17-39
1 X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 16350

FILED MAY 25 1945

Registration District No. 2 Primary Registration District No. 1000 Registrar's No. 554

1. PLACE OF DEATH:

(a) County: Buchanan

(b) City or town: St. Joseph, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Joseph's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 hrs; In this community 72 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

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

(c) City or town: St. Joseph
(If outside city or town limits, write "RURAL")

(d) Street No.: 1709 Dewey Ave
(If rural, give location)

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

If yes, name country:

3. (a) PRINT FULL NAME: John Joseph Farrell

3. (b) If veteran, name war: no

3. (c) Social Security No.: no

4. Sex: Male

5. Color or race: white

6. (a) Single, widowed, married, divorced: widower

6. (b) Name of husband or wife:

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

7. Birth date of deceased: December 23 1872 (Month) (Day) (Year)

8. AGE: Years 72 Months 4 Days 23 If less than one day hr. min.

9. Birthplace: St. Joseph, Mo. (City, town, or county) (State or foreign country)

10. Usual occupation: Plumber

11. Industry or business:

FATHER 12. Name: Patrick Farrell

FATHER 13. Birthplace: Ireland (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name: Mary Lonigan

MOTHER 15. Birthplace: Ireland (City, town, or county) (State or foreign country)

16. (a) Informant: J. J. Farrell Jr

(b) Address: Jefferson City, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-19-45 (Month) (Day) (Year)

(c) Place: burial or cremation: Mt Olivet Cemetery

18. (c) Signature of funeral director: Barry Funeral Home

(b) Address: 224 South 10th, St. Joseph, Mo.

19. (a) 5-19-45 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 16 year 1945 hour 11 minute A M.

21. I hereby certify that I attended the deceased from Aug 1945 to May 16 1945 that I last saw him alive on May 16 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Thrombosis	12 hrs
Due to: Art Sclerosis & Hypertension	years
Due to: also had art sclerosis Heart disease decompensated	3 yrs
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations: 93d	
Of autopsy: above	

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: [illegible] (M. D. or other) MD 5-19-45

Address: St. Joseph Mo. Date signed

1511 (Licensed Embalmer's Statement on Reverse Side)

MAY 28 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 Mollie E. Siebenfaden Fox

Licensed Embalmer No. 4235

P. O. Address St. Joseph 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.