

S. No. 2
M-5-42
7-5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **16908**

FILED JUN 11 1945
Registration District No. **200**

Primary Registration District No. **2000**

Registrar's No. **426**

1. PLACE OF DEATH: **GREENE**
(a) County **Greene**
(b) City or town **Springfield,**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
491 South Nettleton,
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **13 Years**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: **39**
(a) State **Missouri** (b) County **Greene**
(c) City or town **Springfield,**
(If outside city or town limits, write "RURAL")
(d) Street No. **491 South Nettleton**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country.

3. (a) PRINT FULL NAME **James Buchanan Farr**
(b) If veteran, name war **No**
(c) Social Security No. **None**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **May** day **22**
year **1945** hour **3** minute **45 P.M.**

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widower**
(b) Name of husband or wife **LNK.** (c) Age of husband or wife if alive **202** years
7. Birth date of deceased **August 8, 1856**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **May 15, 1944** to **May 27, 1945**
that I last saw **him** alive on **May 21, 1945**
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
<input checked="" type="checkbox"/>	88	9	14	hr. min.

Immediate cause of death
Chr. myocarditis

9. Birthplace **Near Kalamazoo, Mich.**
(City, town, or county) (State or foreign country)

Due to **Chr. hypertensive car. etc. vascular** **1 yr**
Due to

10. Usual occupation **Retired Florist**

Other conditions (include pregnancy within 3 months of death)
Major findings: Of operations **g 3d**
Of autopsy

11. Industry or business

12. Name **Unknown**
13. Birthplace **Canada**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**
15. Birthplace **UNK.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Roy Farr**
(b) Address **491 South Nettleton, Spfld, Mo.**

17. (a) **Burial** (b) Date thereof **5-26-45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Maplepark**

18. (a) Signature of funeral director **W.L. Dunn**
(b) Address **Springfield, Mo.**

19. (a) **5-26-45** (b) **Dr. W. Handley**
(Date received local registrar) (Registrar's signature)

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)

23. Signature **Arthur D. Smith** M.D. or other **old**
Address **450 1/2 E. 1st St. Spfld, Mo.** Date signed **5-25-45**

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

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 J W Maple
Licensed Embalmer No. 2985
P.O. Address Cluer 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.

X