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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. 35242

FILED NOV 29 1945

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10041

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1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Barnes Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Hospital (Specify whether
In this community 14 days.
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 999
(a) State Illinois (b) County St. Clair
(c) City or town East St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1716 N. Park Dr. NR.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Robert Claude Farrier
3. (b) If veteran, name war no
3. (c) Social Security No. none
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Lillian Farrier
6. (c) Age of husband or wife if alive 46 years
7. Birth date of deceased January (Month) 19, (Day) 1887 (Year)

8. AGE: Years 58 Months 10 Days 1 If less than one day hr. min.

9. Birthplace Omaha (City, town, or county) Texas (State or foreign country)
10. Usual occupation Director
11. Industry or business E. Side Health District
MOTHER FATHER
12. Name Frederick Farrier
13. Birthplace Union Springs (City, town, or county) Ala. (State or foreign country)
14. Maiden name Lura Hart
15. Birthplace (City, town, or county) Texas (State or foreign country)
16. (a) Informant Robert M. Farrier
(b) Address 4535 Lindell, St. Louis Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 11-20-45 (Month) (Day) (Year)
(c) Place: burial or cremation E. St. Louis, Ill.
18. (a) Signature of funeral director
(b) Address East St. Louis, Ill.
19. (a) NOV 20 1945 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 20
year 1945 hour 6 minute — A.M.
21. I hereby certify that I attended the deceased from 10-20- 1945, 19..., to 11-20- 1945, 19..., that I last saw him alive on 11-20 1945, 19..., and that death occurred on the date and hour stated above.

Duration

Immediate cause of death Hypertensive Cardio Vascular Dis. Uremia
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?
While at work? (Specify type of place) (e) Means of injury

23. Signature James T. Good (M. D. or other)
Address Barnes Hospital, Date signed 11-20-45

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No. 3162

P. O. Address East St Louis Ill

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.