

FILED JAN 5 1946

Registration District No. 377

Primary Registration District No. 3063

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

1. PLACE OF DEATH:

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Louis
(c) City or town Clayton
(If outside city or town limits, write "RURAL")
(d) Street No. 122 So. Brentwood Blvd
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

J. H. Farrar

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex 7 / 5. Color or race A. 6. (a) Single, widowed, married, divorced M.
6. (b) Name of husband or wife Jesse Farrar 6. (c) Age of husband or wife if alive 84 years
7. Birth date of deceased Oct. 10 1864
(Month) (Day) (Year)

8. AGE: Years 81 Months 2 Days 20 If less than one day hr. _____ min. _____

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

10. Usual occupation Homemaker

11. Industry or business _____

MOTHER FATHER

12. Name Abel
13. Birthplace Germany 4
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Joshua

(b) Address 803 S. Carondelet Ave.

17. (a) Burial (b) Date thereof Jan 2 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lake Charles Cem.

18. (a) Signature of funeral director Wm. H. Bopp, Inc.

(b) Address Kirkwood Mo.

19. (a) 1-3-46 (b) W. M. Garraway, M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 30th
year 1945 hour 4 minute 09 P.M.

21. I hereby certify that I attended the deceased from 4:05 P.M.
12-30-45, 1945, to 4:00 12-30-45, 1945;
that I last saw him alive on 12-30-45, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary Occlusion
Due to: Arteriosclerosis

Due to: 940

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

Major findings: Of operations _____

Of autopsy _____

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 [Signature] Date signed 12/30/45
Address 601 Brentwood Blvd

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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..... *Jan M. Simon*
Licensed Embalmer No..... *4343*
P. O. Address..... *7415 Zephyr Pl
Mingledale, N.Y.*

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.