

3-2
2-43
7-39
3-97

Registration District No. 141

Primary Registration District No. 3025

Registrar's No. 17

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

1. PLACE OF DEATH:

(a) County Hawell
(b) City or town West Plains
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Christa Hogan 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 Hawell
(c) City or town West Plains
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location) 0
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Billy Ray Farel

3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex MD 5. Color or race W 6. (a) Single, widowed, married, divorced Child
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased 11 - 30 - 1943
(Month) (Day) (Year)

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

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

10. Usual occupation Child

11. Industry or business _____

MOTHER FATHER { 12. Name Lehman R. Farel
13. Birthplace Bakersfield Mo
(City, town, or county) (State or foreign country)
14. Maiden name Velma A. Struble
15. Birthplace Vidette Ark
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. R. Farel
(b) Address _____

17. (a) B (b) Date thereof 2-2-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Pleasant View

18. (a) Signature of funeral director Robertson
(b) Address West Plains, Mo

19. (a) Feb. 6, 1946 (b) Blodys Bussard
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 1
year 1946 hour 7 minute 30 A.M.

21. I hereby certify that I attended the deceased from Jan. 6, 1946 to February 1, 1946
that I last saw him alive on January 31, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Meningitis
Duration _____

Due to _____
Due to _____

Other conditions (Includes pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 CI
23. Signature R. H. ...
Address West Plains, Mo 2-2-46

RECEIVED

District Health Officer No 5,

District File Number

246207

Date Filed

3.17.46

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

D. A. Robertson

Licensed Embalmer No.

3432

P. O. Address

West Plains, 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.

Registration District No. 141 Primary Registration District No. 3028

1. PLACE OF DEATH:

(a) County Haskell

(b) City or town West Plains
(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 _____)

In this community _____ years, months or days

3. (a) PRINT FULL NAME Billy R. Farel

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color w 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Nov 30
(Month) (Day) (Year)

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

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____ (b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration _____

Due to _____

Due to _____

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? _____

(d) Did injury occur in or about _____
(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

MISSOURI
STATE BOARD OF HEALTH
REGISTERED
DEATHS
1947

Staw

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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