

S. No. 2
M-5-43
5-17-39
I X3667

State File No. 23036

Registrar's No. 92

FILED AUG 5 1946
Registration District No. 2/1

Primary Registration District No. 3012

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

1. PLACE OF DEATH:

(a) County Clay

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

(c) Name of hospital or institution:
Veterans Administration Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 yrs., 1 mo., 28 days
(Specify whether years, months or days)

In this community 3 yrs., 1 mo., 28 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Iowa (b) County Jackson 999

(c) City or town Preston 13
(If outside city or town limits, write "RURAL") 0

(d) Street No. --- (If rural, give location) 2

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Wayne E. Farley

3. (b) If veteran, name war World War I

3. (c) Social Security No. 478-14-2255

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 20
year 1946 hour 6:30 minute A. M.

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mabelle Farley

6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased June 24 1894
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 22, 1943, to July 20, 1946, that I last saw him alive on July 20, 1946, and that death occurred on the date and hour stated above.

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

52 - 26 hr. min.

Immediate cause of death Tuberculosis, pulmonary, chronic, far advanced Duration Unknown

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

Due to _____

Due to _____

10. Usual occupation Lineman - unemployed

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

11. Industry or business Telephone Company

Major findings: _____
Of operations _____

Of autopsy No autopsy performed

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name Edward Farley

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

14. Maiden name Lillian Mae Smith

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

16. (a) Informant Hospital Records, Veterans Administration, Excelsior Springs, Mo.

(b) Address Removal

17. (a) Removal (b) Date thereof July 20, 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Removal Clinton, Iowa

18. (a) Signature of funeral director Joseph Hope
Hope Funeral Home

(b) Address Excelsior Springs, Missouri

19. (a) 7/22/46 (b) Caroline Hutchings
(Date received local registrar) (Registrar's signature)

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 Joseph Glasser (M. D. or other) O. H. D.

Address Excelsior Springs, Mo. Date signed 7/20/46

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed

8-3-76

01100

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 *Chas Virgil Hope*

Licensed Embalmer No. *3950*

P. O. Address *Excelsior Park*

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. 21 Primary Registration District No. 3012

1. PLACE OF DEATH:
(a) County Clay
(b) City or town Excelsior Springs
(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 Wayne E. Farley
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

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

7. Birth date of deceased June 24 1946
(Month) (Day) (Year)

8. AGE: Years 52 Months _____ Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
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) 7/23/46 (b) Caroline Hatching
(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 _____ Year 1946 hour _____ minute _____ M. _____

21. I hereby certify that I attended the deceased from _____ 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 _____

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? _____
(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 _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY 20

PHYSICIAN

Underline the cause to which death should be charged statistically.

23031