

FILED MAY 12 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12760

Registration District No. 5-8

Primary Registration District No. 4080

Registrar's No. 14

1. PLACE OF DEATH:

(a) County Carter
 (b) City or town Hunter
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
own home
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether
 In this community 12 1/2 10 years _____
 years, months or days)

3. (a) PRINT FULL NAME Rye Raldo Farmer

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

4. Sex MO 5. Color or race w
 6. (a) Single, widowed, married, divorced, widowed
 6. (b) Name of husband or wife Iva Farmer 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased: now 29 1876
 (Month) (Day) (Year)

8. AGE: Years 70 Months 4 Days 19 If less than one day _____ hr. _____ min.9. Birthplace _____ (City, town, or county) (State or foreign country) Ill10. Usual occupation Farmer

11. Industry or business _____

12. Name _____ 96

13. Birthplace _____ (City, town, or county) (State or foreign country) 96

14. Maiden name _____ 96

15. Birthplace _____ (City, town, or county) (State or foreign country) 96

16. (a) Informant Rolda Rigins(b) Address Ellisnore, Mo.17. (a) Burial (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)(c) Place: burial or cremation Belly18. (a) Signature of funeral director Seaton Dewitt(b) Address Van Buren, Mo.19. April 30-47 Mrs Octa Benson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Carter 78
 (c) City or town Hunter
 (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 Apr day 8
year 1947 hour 10 minute 15 A.M.21. I hereby certify that I attended the deceased from 12-8-46, 19____ to 4-8, 1947
that I last saw him alive on 3-30, 1947
and that death occurred on the date and hour stated above.Immediate cause of death Coronary OcclusionDue to Arteriosclerotic heart diseaseDue to Arteriosclerosis, generalized

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

Major findings: Of operations _____

Of autopsy 97B

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 H. D. Curshaw, M.D. (M.D. or other) MDAddress Pyslaw Bluff, Mo. Date signed 4-22-47

RECEIVED

District Health Officer No. 5,

District File Number 542221

Date Filed 5-10-47

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 Seaton Hewitt

Licensed Embalmer No. 2287

P. O. Address Van Buren

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

2B
-45
43880

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. May
Registrar's No. 14

Registration District No. 08

Primary Registration District No. 4090

1. PLACE OF DEATH:

(a) County Carter

(b) City or town Hunter
(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 Ryle W. Farmer

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

4. Sex M 5. Color pr W race _____ 6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased Nov. 29
(Month) (Day) (Year)

8. AGE: Years 70 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 _____

MOTHER FATHER

12. Name Unknown

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

14. Maiden name Unknown

15. Birthplace Unknown
(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 _____

15. (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 _____ Year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw h. _____ 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)

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

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

SUPPLEMENTARY

12700