S. No. 2
1—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED JUN 18 1947

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21480

Registration District No. 1 70

Primary Registration District No. 1632

Registrar's No.

1. PLACE OF DEATH:
(a) County Laclede
(b) City or town Lebanon Rural
(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 entire life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Lacled 53
(c) City or town Lebanon (Rural)
(If outside city or town limits, write "RURAL")
(d) Street No. R R # 4
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME EMMA JANE FARRINGTON
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Female
5. Color or race W
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Will Farrington
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb. (Month) 28 (Day) 1880 (Year)

8. AGE:

Years	Months	Days	If less than one day
67	3	1	hr. min.

9. Birthplace Laclede Co. (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
FATHER
12. Name David Corliss
13. Birthplace Laclede Co. Mo. (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Amanda Robertson
15. Birthplace Missouri (City, town, or county) (State or foreign country)
16. (a) Informant Mrs Rose Price
(b) Address Lebanon R# 4
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-2-47 (Month) (Day) (Year)
(c) Place: burial or cremation Oakland Mo.
18. (a) Signature of funeral director W. E. Holman
(b) Address Lebanon Mo.
19. (a) June 14, 47 (Date received local registrar) (b) Org Frankeberger 152 (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5/29 day 29th year 1947 hour 12 minute 15 P. M.

21. I hereby certify that I attended the deceased from 1/1/47 to 5/29, 1947, that I last saw her alive on 5/29, 1947, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Angina Pectoris	
Due to Acute Cholecystitis	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN

Underline the cause of 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 5/29/47
(c) Where did injury occur? Lebanon (Rural) (City or town) Laclede (County) Mos (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature R G Saunders (M. D. or other) D.O.
Address Lebanon Mo Date signed 5/31/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

Received 6/16/47

Laclede County Health Unit

File No. 6/47/103

Date Filed 6/17/47

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 Dorsey M. House

Licensed Embalmer No. 4222

P. O. Address Lebanon, 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.