

FILED DEC 17 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41045

State File No. _____

Registration District No. 47

Primary Registration District No. 3008

Registrar's No. 429

1. PLACE OF DEATH:

(a) County Calloway
(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital No. 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution same years (Specify whether years, months or days)

3. (a) PRINT FULL NAME LELIA F. FARROW

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

4. Sex F 5. Color or race N 6. (a) Single, widowed, married, divorced D

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

7. Birth date of deceased D.K.
(Month) (Day) (Year)

8. AGE: Years 41 Months _____ Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation none

11. Industry or business _____

MOTHER FATHER

12. Name D.K.

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

14. Maiden name D.K.

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

16. (a) Informant Hospital Records

(b) Address Fulton Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-11-47 (Month) (Day) (Year)

(c) Place: burial or cremation State Hosp. Cemetery

18. (a) Signature of funeral director G. P. Hall

(b) Address State Hosp. #1, Fulton Mo.

19. (a) 12-11-1947 (Date received local registrar) (b) James M. ... (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County City of St. Louis
(c) City or town St. Louis (If outside city or town limits, write "RURAL")
(d) Street No. 1728-A Delmar St. (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 8 year 1947 hour 5 minute P. M.

21. I hereby certify that I attended the deceased from 12-6-47 19 to 12-8-47 19

that I last saw her alive on 12-7-47 19 and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculous Peritonitis
Due to Pulmonary Tuberculosis & cavitation

Due to _____

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

Major findings: Of operations _____ Of autopsy yes

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) (c) Means of injury _____

23. Signature J. G. Caldwell M.D. (M. D. or other) _____

Address Fulton Mo. Date signed 12/8/47

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

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2

✓

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed 12-17-47

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.....

Licensed Embalmer No.....

P. O. Address.....

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.