

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED APR 23 1948  
Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 3617

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

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

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

(c) Name of hospital or institution:  
St. Louis City Hospital—Max C. Starkloff  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 days  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County dal

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 2918 N 23rd. Street,  
Memorial (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME William Walter Farr.

3. (b) If veteran, name war None

3. (c) Social Security No. 499-01-5354

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 13th  
year 1948 hour 10 minute 55 A. M.

21. I hereby certify that I attended the deceased from 4/5/48  
\_\_\_\_\_ 19 \_\_\_\_\_ to April 13th 19 48  
that I last saw him alive on April 13th 19 48  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mary L. Farr. 6. (c) Age of husband or wife if alive 64 years

7. Birth date of deceased October 10, 1890.  
(Month) (Day) (Year)

Immediate cause of death carcinoma of stomach Duration 1 1/2 yrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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

<u>57</u>	<u>6</u>	<u>3</u>	hr. _____ min. _____
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Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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

9. Birthplace St. Charles, Missouri.  
(City, town, or county) (State or foreign country)

10. Usual occupation Foreman

11. Industry or business Hydrolic Brick Co.

MOTHER FATHER

12. Name Alfred Farr.

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

14. Maiden name Annie Windau.

15. Birthplace St. Charles, Missouri.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mary L. Farr.

(b) Address 2918 N 23rd. Street.

17. (a) Burial (b) Date thereof 4-16-1948.  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery.

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 Carl G. Luer M.D. Date signed 4/14/48  
1125 Lafayette Address \_\_\_\_\_

18. (a) Signature of funeral director Geo. L. Pleitsch, Inc.

(b) Address 5966-68 Easton Avenue.

19. (a) APR 16 1948 (Date received local registrar)  
J. F. Brodeur (Registrar's signature)

**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 Clement M. Gray  
Licensed Embalmer No. 3732  
P. O. Address St. Louis

**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.**