FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED JUL 28 1948
Registration District No. 376

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 4462

State File No. 24024

Registrar's No. 221

1. PLACE OF DEATH:
(a) County: St Francois
(b) City or town: Elvins, Mo.
(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 years, months or days)
In this community: 2 hrs 45 min

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: St Francois
(c) City or town: Elvins
(If outside city or town limits, write "RURAL")
(d) Street No.: /
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country: ____

3. (a) PRINT FULL NAME: Leona Sue Farmer
3. (b) If veteran, name war: ____
3. (c) Social Security No.: ____
4. Sex: F
5. Color or race: W
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: June (Month) 28 (Day) 1948 (Year)

8. AGE: Years ____ Months ____ Days ____ If less than one day: 2 hr. 45 min.

9. Birthplace: Elvins (City, town, or county) Mo. (State or foreign country)
10. Usual occupation: None
11. Industry or business: ____
MOTHER FATHER
12. Name: Cives C. Farmer
13. Birthplace: Patton Mo (City, town, or county) (State or foreign country)
14. Maiden name: Pauline Hanson
15. Birthplace: Bos Mo (City, town, or county) (State or foreign country)
16. (a) Informant: Cives C. Farmer
(b) Address: Elvins Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: June 29 1948 (Month) (Day) (Year)
(c) Place: burial or cremation: St Francois Gardens
18. (a) Signature of funeral director: Baldwell Bros
(b) Address: Flat River Mo
19. (a) 7-19-48 (Date received local registrar) (b) Esther Rudloff (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 29 year 1948 hour 1 minute 38 AM.
21. I hereby certify that I attended the deceased from June 28, 1948, to June 29, 1948, that I last saw him alive on June 29, 1948 and that death occurred on the date and hour stated above.

Immediate cause of death: Wor premature and double birth (twin) 3/4 lb

Due to: ____

Due to: ____

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

Major findings: Of operations: ____

Of autopsy: none

Duration: ____

PHYSICIAN: 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? (Specify type of place): ____
While at work? ____ (e) Means of injury: ____

23. Signature: Lois Stanfield (M. D. or other) MD
Address: Farmington Mo Date signed 7/16/48

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 4

District File Number 48-934

Date Filed 2-26-48

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 Not Embalmed., Registered Apprentice No. working under my personal supervision.

Signed W. A. Caldwell

Licensed Embalmer No. S 3317

P. O. Address Flat River

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

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