

FILED MAR 1 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

4246

State File No. ....

Registrar's No. 17

BIRTH NO. _____		REG. DIST. NO. 52		PRIMARY REG. DIST. NO. 5781		State File No. ....		Registrar's No. 17						
1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>near Oak Ridge</u> b. COUNTY <u>Cape Girardeau</u>										
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural, Applecreek</u>				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural - Applecreek</u>										
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>2 miles East Oak Ridge</u>				d. STREET ADDRESS (If rural, give location) _____										
3. NAME OF DECEASED (Type or Print)			a. (First) <u>ROBERT</u>			b. (Middle) <u>WALTER</u>			c. (Last) <u>FARREL</u>			4. DATE OF DEATH Month <u>Feb</u> Day <u>24</u> Year <u>1949</u>		
5. SEX <u>male</u>		6. COLOR OR RACE <u>negro</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>JUNE 5, 1885</u>			9. AGE (In years last birthday) <u>63</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 2 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>		11. BIRTHPLACE (State or foreign country) <u>Neely, Lankin Mo</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13a. FATHER'S NAME <u>Thomas Farrel</u>				13b. MOTHER'S MAIDEN NAME <u>Laura Burrell</u>				14. NAME OF HUSBAND OR WIFE <u>Rosa Lee Farrel</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT'S SIGNATURE OR NAME <u>Rose Lee Farrel</u>		ADDRESS <u>Oak Ridge Mo</u>								
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				<p align="center"><b>MEDICAL CERTIFICATION</b></p> I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Tuberculosis of Lung</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Diabetes</u>								INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)									
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21f. HOW DID INJURY OCCUR?									
22. I hereby certify that I attended the deceased from <u>2-16</u> , 1949, to <u>2-16</u> , 1949, that I last saw the deceased alive on <u>2-16</u> , 1949, and that death occurred at <u>11 a.</u> m., from the causes and on the date stated above.														
23a. SIGNATURE <u>R.D. Playlock M.D.</u>				23b. ADDRESS <u>Oak Ridge Mo</u>				23c. DATE SIGNED <u>2-25-49</u>						
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Feb 27, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Wilson</u>			24d. LOCATION (City, town, or county) (State) <u>near Oak Ridge</u>							
DATE REC'D BY LOCAL REG. <u>Feb 2 1949</u>		REGISTRAR'S SIGNATURE <u>D.G. Suber</u>			43			25. FUNERAL DIRECTOR'S SIGNATURE <u>R. Miller</u> ADDRESS <u>Jackson</u>						

(Licensed Embalmer's Statement on Reverse Side)

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

MAR 18 1949

RECEIVED

Health Officer No. 4  
File Number 249-293  
Date Filed 2-28-49

MAR 18 1949

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed Gene C. Caccoff

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 4337

P. O. Address Fachon, 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.