

FILED MAR 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1858

318

1003

No. 300
10-48
17

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.				
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY About 10						
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis - Missouri		c. LENGTH OF STAY (In this place) 30 days		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis University City 3						
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Childrens Hospital				d. STREET ADDRESS (If rural, give location) # 47 Faculty Lane 1						
3. NAME OF DECEASED (Type or Print)			a. (First) Lewis b. (Middle) Marshall c. (Last) FARR			4. DATE OF DEATH (Month) (Day) (Year) FEBRUARY 26 1949				
5. SEX male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) ()		8. DATE OF BIRTH 1-30-43				
9. AGE (In years last birthday) 6 yr		IF UNDER 1 YEAR Months 0		IF UNDER 24 HRS. Days 26		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Greenville - Mississippi		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME Lewis FARR, M.D.			13b. MOTHER'S MAIDEN NAME Alice Miller			14. NAME OF HUSBAND OR WIFE				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Lewis Farr - 47 FACULTY LANE -					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH			
<p>*This does not mean the mode of dying, such as heart failure, athermia, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Meningitic (Post-op.)					2 weeks			
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (c) stating the underlying cause last.					DUE TO (b) Ependymoma of 4th Ventricle 5H ⁶		8 months	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.								
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 192X						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) (Min.)		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 1-27, 1949, to 2-26, 1949, that I last saw the deceased alive on 2-26, 1949, and that death occurred at 7:35 p. m., from the causes and on the date stated above.										
23a. SIGNATURE (Degree or title) Wm. Klingberg, M.D.				23b. ADDRESS St. Louis Childrens Hospital		23c. DATE SIGNED 2/26/49				
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 2/27/49		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) Leland, Mississippi				
DATE REC'D. BY LOCAL HEALTH DEPT. FEB 28 1949				REGISTRAR'S SIGNATURE J. B. Foster		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C.R. Lupton & Sons - 7233 Delmar Blvd University City, Mo.				

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

(Licensed Embalmer's Statement on Reverse Side)

8987

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.

Student

Student Embalmer

Signed Clarence H. Murray

Licensed Embalmer No. 4011

P. O. Address St. Louis, 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.