

FILED MAY 16 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14888

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 511

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph	
c. LENGTH OF STAY (in this place) 5 weeks		d. STREET ADDRESS (If rural, give location) 2207 Penn St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 927 1/2 W. Hyde Park Ave.			

3. NAME OF DECEASED (Type or Print) a. (First) NANCY	b. (Middle) JANE	c. (Last) FARRAR	4. DATE OF DEATH (Month) (Day) (Year) 5 2 1949
---	------------------	------------------	---

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 8-17-1873	9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months	IF UNDER 4 HRS. Hours Min.
---------------	------------------------	--	----------------------------	------------------------------------	------------------------	----------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Davies Co., Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	--	---	--

13a. FATHER'S NAME David M. Slaughter	13b. MOTHER'S MAIDEN NAME Virginia M. Hawk	14. NAME OF HUSBAND OR WIFE Virgil Farrar
--	---	--

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 Mrs. Dick Turner, 927 1/2 W. Hyde Park	ADDRESS Hyde Park
--	---------------------------------	---	----------------------

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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 4/1/49-
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Cerebral Hemorrhage</i>		-
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Hypertension</i> DUE TO (c) <i>arteriosclerotic</i>		-
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			331X

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) (Minute)	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 4/1, 1949, to 4/27, 1949, that I last saw the deceased alive on 4/29, 1949, and that death occurred at 10:35 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>Stanley J. Handegan MD</i>	23b. ADDRESS St. Joseph, Missouri <i>670 Thross St.</i>	23c. DATE SIGNED 5/4/1949
---	---	------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 5/4/1949	24c. NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery	24d. LOCATION (City, town, or county) (State) Pattensburg, Missouri
---	-----------------------	---	--

DATE REC'D BY LOCAL REG. May 10, 1949	REGISTRAR'S SIGNATURE <i>E. G. Jenkins</i>	382	25. FUNERAL DIRECTOR'S SIGNATURE <i>John C. Cuff</i>	ADDRESS St. Joseph, Mo.
--	---	-----	---	----------------------------

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

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.....
Student Embalmer

Signed John E. Rupp
Licensed Embalmer No. 3986
P. O. Address St. Joseph, 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.