

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

25519

State File No. ....

FILED AUG 2 1949

BIRTH NO. 44657-49 REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 3069 Registrar's No. 1825

1. PLACE OF DEATH a. COUNTY <u>Saint Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Richmond Heights</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Saint Louis</u>	
c. LENGTH OF STAY (in this place) <u>17 days</u>		d. STREET ADDRESS (If rural, give location) <u>6419 Vermont</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Saint Mary's Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>James</u> b. (Middle) <u>Dorsey</u> c. (Last) <u>Farley</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July 27 1949</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>1</u>	8. DATE OF BIRTH <u>July 10, 1949</u>	9. AGE (In years last birthday) <u>17 days</u>	IF UNDER 1 YEAR Months Days
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) <u>St. Louis Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13a. FATHER'S NAME <u>James T. Farley</u>	13b. MOTHER'S MAIDEN NAME <u>Anna Scanio</u>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>James T. Farley</u> ADDRESS <u>6419 Vermont St. Louis, Mo.</u>
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH  <u>7620</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Surgical Shock - Atelectasis</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Intest Duodenal Obstruction</u> DUE TO (c) <u>Congenital Band</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Atelectasis and Pneumonia</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from July 16, 1949, to July 27, 1949, that I last saw the deceased alive on July 27, 1949, and that death occurred at 12:55 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Eugene Henry Ebel Jr. M.D.</u>	23b. ADDRESS <u>St. Mary's Hospital</u>	23c. DATE SIGNED <u>7-27-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>7-28-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Saint Louis County, Missouri</u>
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DATE REC'D BY LOCAL REG. <u>7-28-49</u>	REGISTRAR'S SIGNATURE <u>Herbert R. ...</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert J. Ambruster, Inc. 6633 Clayton Rd.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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**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 Ernest W. Spillars

Signed.....  
Student Embalmer

Licensed Embalmer No. 4080

P. O. Address.....

**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.

*[Handwritten mark]*