Dr. G. Farthing

No. 300
10.48

FILED SEP 26 1949

STANDARD CERTIFICATE OF DEATH

29929

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 841

1. PLACE OF DEATH
a. COUNTY: Greene
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Springfield
c. LENGTH OF STAY (in this place): 15 Yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 900 S. Weaver

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: Greene
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Springfield
d. STREET ADDRESS (If rural, give location): 900 S. Weaver

3. NAME OF DECEASED (Type or Print)
a. (First): Mary
b. (Middle): O.
c. (Last): Smith

4. DATE OF DEATH (Month) (Day) (Year): Sept. 17, 1949

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: April 15 1861
9. AGE (In years last birthday): 88 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Grand Fork, Illinois
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Unknown
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: X

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: No
17. INFORMANT'S SIGNATURE OR NAME: J.W. Seabaugh
ADDRESS: Springfield, Mo.

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

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Rectum. — INTERVAL BETWEEN ONSET AND DEATH: 2 years

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.

154X

19a. DATE OF OPERATION: Dec '47
19b. MAJOR FINDINGS OF OPERATION: Carcinoma of Rectum with metastases.
20. AUTOPSY? YES ☐ NO ☑

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ~~Dec~~ Aug, 19 47, *to* Sept, 19 49, *that I last saw the deceased alive on* Aug 1, 1947, *and that death occurred at* 5 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE: Gene W. Farthing (Degree or title) M.D.
23b. ADDRESS: Holland Bldg, Springfield
23c. DATE SIGNED: 9.19.49.

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/19/49
24c. NAME OF CEMETERY OR CREMATORY: Eastlawn
24d. LOCATION (City, town, or county) (State): Springfield, Mo.

DATE REC'D BY LOCAL REG.: 9-20-49
REGISTRAR'S SIGNATURE: W E Handley by O [illegible]
25. FUNERAL DIRECTOR'S SIGNATURE: H.H. Lohmeyer
ADDRESS: Springfield, Mo.

(Attach Embalmer's Statement on Reverse Side)

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.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

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.