

FILED DEC 14 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **38702**  
Registrar's No. **10445**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>10445</b>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>2000</b>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) <b>25 year</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Mary's Infirmary</b>				d. STREET ADDRESS (If rural, give location) <b>1230 Armstrong</b>			
3. NAME OF DECEASED a. (First) <b>Rev. Pete</b>			b. (Middle) _____		c. (Last) <b>Farrar Jr.</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>11-30-49</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>May 14, 1890</b>	9. AGE (In years last birthday) <b>59</b>	IF UNDER 1 YEAR Months <b>6</b> Days <b>16</b>	IF UNDER 1 HR. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <b>St. Joseph, La.</b>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <b>Pete Farrar</b>		13b. MOTHER'S MAIDEN NAME <b>Fine Reed</b>		14. NAME OF HUSBAND OR WIFE <b>Elizabeth Farrar</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Elizabeth Farrar 1230 Armstrong</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pulmonary Embolism</b> ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) <b>Peripheral Vascular Disease</b> DUE TO (c) <b>Disease &amp; Ulcer of Foot</b>			INTERVAL BETWEEN ONSET AND DEATH _____
19a. DATE OF OPERATION <b>8/12/49</b>		19b. MAJOR FINDINGS OF OPERATION <b>Peripheral Vascular Disease</b>				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) <b>St. Louis</b>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>H-333</b>			
22. I hereby certify that I attended the deceased from <b>8/12, 1949</b> , to <b>11/30, 1949</b> that I last saw the deceased alive on <b>11/30, 1949</b> and that death occurred at <b>4:00 p.m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <i>[Signature]</i>				23b. ADDRESS <b>822 N. - e Farrarson</b>		23c. DATE SIGNED <b>12/24/49</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Dec. 7, 1949</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, County, Mo.</b>	
DATE REC'D BY LOCAL REG. <b>DEC 5 1949</b>		REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Dement &amp; Son 2629-31 Cole Street</b>			

**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 H. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 4575 Aldine

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**