

FILED DEC 7 1950

STANDARD CERTIFICATE OF DEATH

State File No. 36416

BIRTH NO. _____ REG. DIST. NO. 5 PRIMARY REG. DIST. NO. 2238 Registrar's No. 39

1. PLACE OF DEATH
 a. COUNTY Cedar
 b. CITY OR TOWN *Humansville, Jefferson Co. Mo.*
 c. LENGTH OF STAY (If in this place) _____
 d. FULL NAME OF HOSPITAL OR INSTITUTION *8 Mi. S.W. of Humansville*

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
 a. STATE Missouri
 b. COUNTY Cedar
 c. CITY OR TOWN *Humansville, Jefferson Co. Mo.*
 d. STREET ADDRESS *8 Mi. S.W. of Humansville*

3. NAME OF DECEASED
 a. (First) James
 b. (Middle) Thomas
 c. (Last) Farmer
 4. DATE OF DEATH 11 11 1950

5. SEX Male
 6. COLOR OR RACE wh
 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED *Widowed*
 8. DATE OF BIRTH Jan 9 1872
 9. AGE (In years last birthday) 78 Months 10 Days 2

10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) Farmer
 10b. KIND OF BUSINESS OR INDUSTRY Farming
 11. BIRTHPLACE (State or foreign country) S.W. Mo.
 12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME *William Johnson Farmer*
 13b. MOTHER'S MAIDEN NAME *Net Brown*
 14. NAME OF HUSBAND OR WIFE *Susan Farmer*

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 *Ozzie Farmer Humansville 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, asphyxia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) *Carcinoma of nose*
 ANTECEDENT CAUSES *& right eye with metastases*
 Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
 DUE TO (b) *to brain*
 DUE TO (c)
 II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.
 INTERVAL BETWEEN ONSET AND DEATH
 yrs. *No OX*

19a. DATE OF OPERATION
 19b. MAJOR FINDINGS OF OPERATION
 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)
 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 _____, 19____, to _____, 19____, that I last saw the deceased alive on *11/10/50*, 1950, and that death occurred at *1:15 P. m.*, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) *Wm B Richter M.D.*
 23b. ADDRESS *Stockton Mo.*
 23c. DATE SIGNED *11.18.50*

24a. BURIAL, CREMATION, REMOVAL (Specify) *Burial*
 24b. DATE *Nov 15 1950*
 24c. NAME OF CEMETERY OR CREMATORY *Star Ridge Cemetery*
 24d. LOCATION (City, town, or county) (State) *Jeff. Co. Mo.*

DATE REC'D BY LOCAL REG. *11-24-1950*
 REGISTRAR'S SIGNATURE *Genevieve Garrison*
 25. GENERAL DIRECTOR'S SIGNATURE ADDRESS *Genevieve Garrison*

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

02021

DIVISION OF HEALTH OF MO.

District No. 5 - Springfield

RECEIVED NOV 29 1950

Dist. File 1250-2365

Date Filed 12-5-50

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 _____

working under my personal supervision.

Student Embalmer No.

Signed

Shepard B. Curwin

Signed.....
Student Embalmer

Licensed Embalmer No. 3092

P. O. Address Bolivar, 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.