

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

25718

State File No.

No. 309
10-48
FILED AUG 9 1951

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 2815

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Reynolds	
b. CITY (If outside corporate limits, write RURAL and give township) Ballwin		c. CITY (If outside corporate limits, write RURAL and give township) Ellington	
c. LENGTH OF STAY (in this place) 1 yr.		d. STREET ADDRESS (If rural, give location) 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION Pine Crest Nursing Home			

3. NAME OF DECEASED (Type or Print) Roxanna		a. (First) Roxanna		b. (Middle) Farr		c. (Last) Farr		4. DATE OF DEATH (Month) (Day) (Year) Aug. 1, 1951	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH June 6, 1869		9. AGE (In years last birthday) 82	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ellington, Mo.			12. CITIZEN OF WHAT COUNTRY? U.S.		

13a. FATHER'S NAME Calvin Smith		13b. MOTHER'S MAIDEN NAME Priscilla Helzey		14. NAME OF HUSBAND OR WIFE Anderson	
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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) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Phyllis Miller		ADDRESS 6436a Dale Ave.	
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Cardiac Dilatation		ANTECEDENT CAUSES				1 day	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Chronic myocarditis				1 yr.	
		DUE TO (c)					
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death. 4201					

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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		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 6/1, 1950, to 8/1, 1951, that I last saw the deceased alive on 7/28, 1951, and that death occurred at 7:35a m., from the causes and on the date stated above.

23a. SIGNATURE W. Sheslie		23b. ADDRESS Ellington, Mo.		23c. DATE SIGNED 8/1/51	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 8-1-51		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) Ellington, Mo.	
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DATE REC'D BY LOCAL REG. 8/1/51		REGISTRAR'S SIGNATURE Herbert C. Hamke		25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe		ADDRESS 4700 Washington Blvd.	
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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.

Student
Student Embalmer

Signed

John S. Dennis
Licensed Embalmer No. *4199*
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.