

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

2767
0051

State File No. _____
Registrar's No. _____

FILED JAN 16 1952

318

1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.	c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 21590	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4327 Grace Ave.		d. STREET ADDRESS (If rural, give location) 4327 Grace	

3. NAME OF DECEASED (Type or Print) Mary Alicia Farner			4. DATE OF DEATH Jan. 3, 1952		
a. (First)	b. (Middle)	c. (Last)	(Month)	(Day)	(Year)

5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Jun. 26, 1882	9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months	IF UNDER 11 HRS. Days	Hours	Min.
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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) Missouri 0	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME James Barnes	13b. MOTHER'S MAIDEN NAME M. Cox	14. NAME OF HUSBAND OR WIFE James Farner
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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. no	17. INFORMANT'S SIGNATURE OR NAME Mrs. Mary Blank	ADDRESS
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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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ ANTECEDENT CAUSES Coronary thrombosis 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.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION As above	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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? H201
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **230 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE Tatrick Taylor	(Degree or title)	23b. ADDRESS 1200 Clark	23c. DATE SIGNED 1/4/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 1-4-52	24c. NAME OF CEMETERY OR CREMATORY Sedalia, Mo.	24d. LOCATION (City, town, or county) (State) Sedalia, Mo.
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DATE RECD BY LOCAL REGISTRAR'S SIGNATURE JAN 4 1952 Pearl Smith	25. FUNERAL DIRECTOR'S SIGNATURE Southern Funeral Home	ADDRESS 6322 S. Grand Blvd.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

S. No. 300
v. 10.48

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 *myself*

Student Embalmer No. _____

Student
Student Embalmer

Signed *David Lee Fossan*

Licensed Embalmer No. *4242*

P. O. Address *6322 So Grand*

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.