

FEB 18 1952

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 5779

BIRTH NO. 124 REG. DIST. NO. 215 PRIMARY REG. DIST. NO. 5783 Registrar's No. 4

1. PLACE OF DEATH a. COUNTY Miller		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Miller	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Dixon, Rural Richwoods		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Dixon, Rural Richwoods 0660	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) Walter c. (Last) Farrow			4. DATE OF DEATH (Month) (Day) (Year) Jan. 23, 1952		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH March 30, 1874	9. AGE (In years last birthday) 77	# UNDER 1 YEAR 9 # UNDER 1 MONTH 23 # UNDER 1 HOUR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri	
13a. FATHER'S NAME Henry P. Farrow			13b. MOTHER'S MAIDEN NAME Sarah Ann Mattox		14. NAME OF HUSBAND OR WIFE Nettie Farrow

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 Wayne Farrow		ADDRESS Dixon, Mo. R. R. 3
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Prostate		DUPLICATE OF (b) _____			
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUPLICATE OF (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 177X	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)
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?

22: I hereby certify that I attended the deceased from June, 1948, to Jan. 23, 1952, that I last saw the deceased alive on Jan. 20, 1952, and that death occurred at 7:30 p. m., from the causes and on the date stated above.

23a. SIGNATURE M. A. Gould (Degree or title) D.O.		23b. ADDRESS Iberia; Mo.	23c. DATE SIGNED 1/26/52
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Jan. 25/52	24c. NAME OF CEMETERY OR CREMATORY Jim Matt Lawson Cemetery	24d. LOCATION (City, town, or county) (State) Miller County Mo.
DATE REC'D BY LOCAL REG. Jan-26-52	REGISTRAR'S SIGNATURE 195 Jessie Perkins	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Walter P. Hedges Iberia, Mo.	

(Licensed Embalmer's Statement on Reverse Side)

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

STATE OF MISSISSIPPI  
DEPARTMENT OF HEALTH  
BUREAU OF PUBLIC HEALTH

**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 Walter F. Wedges

Licensed Embalmer No. 4265

P. O. Address Stennis, Miss

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.