

MAY 1 - 1952

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. 14247

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3833

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 town or township) St. Louis		c. LENGTH OF STAY (In this place) Life	c. CITY (If outside corporate limits, write RURAL and give township) St. Louis 2239				
d. FULL NAME OF HOSPITAL OR INSTITUTION Bethesda Hospital			d. STREET ADDRESS (If rural, give location) 23 158 Sidney 0				
3. NAME OF DECEASED (Type or Print) WILLIAM		a. (First)	b. (Middle) E.	c. (Last) FARR	4. DATE OF DEATH (Month) (Day) (Year) 4 20 52		
5. SEX M 0	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NM 0		8. DATE OF BIRTH March 15, 1957	9. AGE (In years last birthday) 1	IF UNDER 1 YEAR Months Days	IF UNDER 1 HR. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri U		12. CITIZEN OF WHAT COUNTRY? US	
13a. FATHER'S NAME Robert Farr		13b. MOTHER'S MAIDEN NAME Jesse Martin		14. NAME OF HUSBAND OR WIFE			
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 Robert Farr 158 Sidney			
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) Gastro-enteritis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Virus Infection 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 4 days 4 days	
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION				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)			
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 571.0			
22. I hereby certify that I attended the deceased from April 18, 1952, to April 30, 1952, that I last saw the deceased alive on Apr 20, 1952, and that death occurred at 4:50 P. M., from the causes and on the date stated above.							
23a. SIGNATURE Leroy E. Ellison M.D.				23b. ADDRESS 3610 So Broadway St. Mo		23c. DATE SIGNED APR 22 1952	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 4-25-52	24c. NAME OF CEMETERY OR CREMATORY Mt. Hope		24d. LOCATION (City/town, or county) (State) St. Louis Co. Mo.		
DATE REC'D BY LOCAL REG. APR 23 1952		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS McLaughlin F. Home 2301 Lafayette Ave.			

WRITE PLAINLY—USING UNFAADING 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 H. G. Farris

Licensed Embalmer No. 3384

P. O. Address 7301 Lafayette

**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.