

FILED SEP 30 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31234**

BIRTH NO. _____ REG. DIST. NO. **118** PRIMARY REG. DIST. NO. **4187** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Franklin		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Missouri b. COUNTY Franklin	
b. CITY (If outside corporate limits, write RURAL and give township) Union		c. CITY (If outside corporate limits, write RURAL and give township) Union	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 117 Christina St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 117 Christina St.			

3. NAME OF DECEASED (Type or Print) a. (First) Nancy V. b. (Middle) Farrar c. (Last) Farrar			4. DATE OF DEATH (Month) (Day) (Year) September 19, 1952					
5. SEX Female	6. COLOR OR RACE White	MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 25th 1878	9. AGE (In years last birthday) 74	IF UNDER 1 YEAR Months 1	IF UNDER 24 HRS. Days 24	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY House work		11. BIRTHPLACE (State or foreign country) Leslie Mo.		12. CITIZEN OF WHAT COUNTRY? USA		

13a. FATHER'S NAME George Childers		13b. MOTHER'S MAIDEN NAME F. Stewig		14. NAME OF HUSBAND OR WIFE Charles Farrar		
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		INFORMANT'S SIGNATURE OR NAME Ruth Willson Union, Mo.		ADDRESS Union, 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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerosis Cardiovascular		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yrs
	ANTECEDENT CAUSES Disease		
	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 4221	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 **3-31**, 19**49** to **Sept 19**, 1952, that I last saw the deceased alive on **Sept 19**, 1952, and that death occurred at **8:30 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE B. H. Stehlerman	(Degree or title) 0	23b. ADDRESS Union, Mo.	23c. DATE SIGNED 9-23-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9/22/52	24c. NAME OF CEMETERY OR CREMATORY Union	24d. LOCATION (City, town, or county) (State) Union, Mo.
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DATE REC'D BY LOCAL REG. Sept 22 1952	REGISTRAR'S SIGNATURE J. T. Cooper	25. FUNERAL DIRECTOR'S SIGNATURE E. F. Oldham	ADDRESS Union, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

2361

NOV 5 1952

OCT 8 1952

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 E. H. Olman

Licensed Embalmer No. 1686

P. O. Address Union 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.