

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB 3 1953

State File No. 3067

BIRTH NO. 89598 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 0616

1. PLACE OF DEATH a. COUNTY <u>St. Louis - Missouri</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Gagconade</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Owensville</u> <u>0370</u>	
c. LENGTH OF STAY (In this place) <u>6 days</u>		d. STREET ADDRESS (If rural, give location) <u>R.R. # 2</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis Children's Hospital</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>James</u>		b. (Middle) <u>Mack</u>	
c. (Last) <u>Farris</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>1 - 17 - 53</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single - 1</u>	8. DATE OF BIRTH <u>12-13-52</u>
9. AGE (In years last birthday) <u>1</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Owensville, Missouri</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Harold Farris</u>		13b. MOTHER'S MAIDEN NAME <u>Lula Willis</u>	
14. NAME OF HUSBAND OR WIFE <u>None</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Harold Farris, Owensville, Mo.</u>	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coarctation of the aorta (pre. ductile)</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 mon.</u>
ANTECEDENT CAUSES 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	
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 <u>7545</u>	
22. I hereby certify that I attended the deceased from <u>1-12</u> , 1953, to <u>1-17</u> , 1953, that I last saw the deceased alive on <u>1-17</u> , 1953, and that death occurred at <u>11:35 a.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>John C. Herweg M.D.</u>		23b. ADDRESS <u>Children's Hospital</u>	
23c. DATE SIGNED <u>1-17-53</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>1-18-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Owensville, Mo.</u>	
24d. LOCATION (City, town, or county) (State)			
DATE REC'D BY LOCAL REG. <u>JAN 19 1953</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Albert H. Hoppe, 4700 Washington Blvd.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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 J. Harris

..... Licensed Embalmer No. *4108*

P. O. Address *St Louis 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.