

STANDARD CERTIFICATE OF DEATH

State File No. 15377

 FILED MAY 4 1953
 BIRTH NO. _____ REG. DIST. NO. 314 PRIMARY REG. DIST. NO. 4459 Registrar's No. 23

1. PLACE OF DEATH a. COUNTY St. Clair		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Clair	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Osceola		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Osceola 0930	
c. LENGTH OF STAY (in this place) 10 days		d. STREET ADDRESS (If rural, give location) 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION Todd's Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Rachel b. (Middle) Elvessa c. (Last) Farmer			4. DATE OF DEATH (Month) (Day) (Year) April 24, 1953			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH Nov. 23, 1872	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months Days	IF UNDER 18 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail Clerk		10b. KIND OF BUSINESS OR INDUSTRY Clothing	11. BIRTHPLACE (State or foreign country) Milford Illinois		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME William W. Farmer		13b. MOTHER'S MAIDEN NAME Unknown Melira		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. 495-07-8266		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Wallace Farmer, Nevada Missouri	

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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocarditis		INTERVAL BETWEEN ONSET AND DEATH 18 days
	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. diabetes 4222		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	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 4-6 1953, to 4-24 1953, that I last saw the deceased alive on 4-23 1953, and that death occurred at 8:30 a. m., from the causes and on the date stated above.

23a. SIGNATURE Ruth Seewers, M.D.	(Degree or title)	23b. ADDRESS Osceola Mo	23c. DATE SIGNED 4-25-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-26-1953	24c. NAME OF CEMETERY OR CREMATORY Osceola	24d. LOCATION (City, town, or county) (State) Osceola Missouri
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DATE REC'D BY LOCAL REG. 4-25-53	REGISTRAR'S SIGNATURE Ruth Seewers	25. FUNERAL DIRECTOR'S SIGNATURE J.B. Basalish	ADDRESS Osceola Mo
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(Licensed Embalmer's Statement on Reverse Side)

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

930

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 *F. J. Hendrich*

Licensed Embalmer No. 3038

P. O. Address *Essex 240*

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.