

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33076

State File No. ....

FILED SEP 24 1953

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Registrar's No. 8146

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 township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place)	c. CITY OR TOWN St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) Belle b. (Middle) Farrar c. (Last) Davis		4. DATE OF DEATH (Month) (Day) (Year) 8 19 53	
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 8-7-1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years last birthday) 58 If UNDER 1 YEAR Months Days If UNDER 4 HRS. Hours Min.
11. BIRTHPLACE (City and State or Foreign Country) Kennet, Mo		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Ned FARRAR		13b. MOTHER'S MAIDEN NAME Mollie FRANKLIN	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. -	17. INFORMANT'S SIGNATURE OR NAME ADDRESS MRS MINNIE FARRAR 4576 EVANS
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) Hypertension Arteriosclerosis 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. Cerebral Thrombosis	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT (Specify) SUICIDE HOMICIDE		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 3132X
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 8-7, 1953, to 8-19, 1953, that I last saw the deceased alive on 8-19, 1953, and that death occurred at 11:15A.M., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) E. B. Williams, M.D.		23b. ADDRESS 2601 N. Whittier	23c. DATE SIGNED 8-19-53
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 8-24-1953	24c. NAME OF CEMETERY OR CREMATORY Washington Park	24d. LOCATION (City, town, or county) (State) St. Louis, Co., Mo.
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE AUG 22 1953 J. Earl Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS A. L. Beal Und Co - 4323 Delmar	

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

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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.....  
Signature of Student Embalmer

Signed *Daniel W. Hughes*.....

Licensed Embalmer No. *4802*.....

P. O. Address *3123 Rolla*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.