

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5487

State File No.

 BIRTH NO. _____ REG. DIST. NO. 212 PRIMARY REG. DIST. NO. 3044 Registrar's No. 5

1. PLACE OF DEATH a. COUNTY <u>Miller</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Cole</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Eldon</u>		c. CITY OR TOWN <u>St. Joseph City</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Schneider Nursing Home</u>		e. STREET ADDRESS (If rural, give location) <u>408 Broadway 0267</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Luzanna</u> b. (Middle) <u>Mathilda</u> c. (Last) <u>Farmer</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 28 - 1954</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Aug. 11 - 1875</u>
9. AGE (In years last birthday) <u>78</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Mins. _____
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Cole County - Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Fountzin Hale</u>	
13b. MOTHER'S MAIDEN NAME <u>Sarah Spinningfield</u>		14. NAME OF HUSBAND OR WIFE <u>Joseph Farmer (Dec)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or of unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>James Farmer</u>		ADDRESS <u>J.C. 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Wrenia</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chr. Nephritis + vascul. disease</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Fracture left hip.</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>592XF</u>	
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) _____		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 <u>Feb 10</u> , 19 <u>54</u> , to <u>Feb 28</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>Feb 27</u> , 19 <u>54</u> , and that death occurred at <u>12:10 P.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>E. Oshelton M.D.</u>		23b. ADDRESS <u>Eldon, Mo.</u>	
23c. DATE SIGNED <u>Feb 1 1954</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Mar 2 1954</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Hickory Hill</u>		24d. LOCATION (City, town, or county) (State) <u>Cole County Mo.</u>	
DATE REC'D BY LOCAL REG. <u>Mar 1, 1954</u>		REGISTRAR'S SIGNATURE <u>Alvaretta Walt</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Anderson - Simon</u>		ADDRESS <u>J.C. Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

Shelton

RECEIVED

MAR 22 1954

MILWAUKEE COUNTY
DEPARTMENT

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.....
[Handwritten Signature]

Licensed Embalmer No. *369*

P. O. Address.....
[Handwritten Address]

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.