

FILED OCT 18 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33063

State File No.

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 1070

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>	c. LENGTH OF STAY (in this place) <u>56 yrs</u>	c. CITY OR TOWN <u>St. Joseph</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 HOSPITAL OR INSTITUTION <u>Wells Nursing Home</u>		e. STREET ADDRESS (If rural, give location) <u>421 E. Colorado Ave.</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>ANNA</u>	b. (Middle) <u>MARGARET</u>	c. (Last) <u>FARRINGTON</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 30, 1954</u>
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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>Sept. 3, 1865</u>	9. AGE (In years last birthday) <u>89</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 4 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Streator, Illinois</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>George Temple</u>	13b. MOTHER'S MAIDEN NAME <u>Jane Stevenson</u>	14. NAME OF HUSBAND OR WIFE <u>Thomas Farrington</u>
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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 <u>George Farrington</u>	ADDRESS <u>605 E. Missouri</u>
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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 <u>St. Joseph, Mo.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>undet.</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Gangrene Rt Leg</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>arteriosclerosis</u>		
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"/>
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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) <u>St. Joseph, Mo.</u>
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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? _____
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22. I hereby certify that I attended the deceased from aug, 1952 to 9-30, 1954, that I last saw the deceased alive on 9-29, 1954, and that death occurred at 11:45 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Clarence C. [Signature]</u>	(Degree or title) _____	23b. ADDRESS <u>St Joseph Mo</u>	23c. DATE SIGNED <u>10-5-54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Oct. 2, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows Public Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>Oct 11, 1954</u>	REGISTRAR'S SIGNATURE <u>Kathleen M. Allison</u>	485	25. FUNERAL DIRECTOR'S SIGNATURE <u>Clark Funeral Home</u>	ADDRESS <u>St. Joseph, Mo.</u>
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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.....
Signature of Student Embalmer

Signed..... *Emilia Clark*

Licensed Embalmer No. *423*

P. O. Address *St. George*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.