

Health, Welfare, Public Service
 0000-1-56
 ALL diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED DEC 6 - 1956

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

40079

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 2806

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>RICHMOND HEIGHTS</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>MAPLEWOOD 4324</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. MARYS Hosp.</u> Length of stay in lb <u>12 DAYS</u>		d. STREET ADDRESS (If outside, give location) <u>7385 FLORA</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>JOHN C FARIS</u> First Middle Last			4. DATE OF DEATH <u>11-25-56</u> Month Day Year				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-30-1896</u>		9. AGE (In years last birthday) <u>59</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>11</u> Days <u>26</u> Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RESTAURANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWNER</u>		11. BIRTHPLACE (City and state or country) <u>WOLF ISLAND ILL</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DAVID-FARIS</u>			14. MOTHER'S MAIDEN NAME <u>VENETTA-STROHM</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>430-264-990</u>		17. INFORMANT <u>HELEN HART FARIS-7385 FLORA</u> Address		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adeno carcinoma of Sigmoid with Metastasis in liver</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 Months</u>
Conditions, if any, which gave rise to above - cause - (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). <u>153X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY. Hour _____ a. m. _____ p. m. Month, Day, Year _____						
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____		

21. I attended the deceased from <u>3-13-56</u> to <u>11-25-56</u> and last saw him <u>xxx</u> alive on <u>11-25-56</u> Death occurred at <u>10:15 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Vincent J. Townsend MD</u> (Degree or title)				22b. ADDRESS <u>3101a Sutton Ave. Maplewood 17, Mo.</u>		22c. DATE SIGNED <u>11-26-56</u>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>11-28-56</u>		23c. NAME OF CEMETERY OR CREMATORY <u>OAK-GROVE CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS CO MO</u>	
24. FUNERAL DIRECTOR <u>JAY B. SMITH-Maplewood-17-Mo</u> ADDRESS			25. DATE RECD. BY LOCAL REG. <u>11-27-56</u>		26. REGISTRAR'S SIGNATURE <u>Herbert A. Romble MD</u>		

JUN 21 1951

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 *H. R. Burgess*

Licensed Embalmer No.

P. O. Address

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