

No. 300
10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40300

FILED NOV 23 1956

6115 State File No.
3074 Registrar's No. 176

333

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY <i>Scott</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <i>Mo</i> b. COUNTY <i>Scott</i>	
b. CITY OR TOWN <i>Likeston</i>		c. CITY OR TOWN <i>Likeston</i>	
c. LENGTH OF STAY (in this place) <i>10 hours</i>		d. 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 <i>Mo. Delta Comm</i>			
e. STREET ADDRESS (If rural, give location) <i>135 Engram</i>			

3. NAME OF DECEASED (Type or Print) a. (First) <i>Loyal</i> b. (Middle) <i>David</i> c. (Last) <i>Farris</i>			4. DATE OF DEATH (Month) (Day) (Year) <i>11-11-1956</i>		
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5. SEX <i>Male</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Never Married</i>		8. DATE OF BIRTH <i>10-31-1937</i>		9. AGE (In years last birthday) <i>19</i>		IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>		IF UNDER 18 HRS. Hours <i>0</i> Min. <i>0</i>	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Factory</i>			11. BIRTHPLACE (City and State or Foreign Country) <i>Urbansville Ky.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
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13a. FATHER'S NAME <i>Ernest Farris</i>			13b. MOTHER'S MAIDEN NAME <i>Davidie Furlow</i>			14. NAME OF HUSBAND OR WIFE _____		
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <i>Ernest Farris</i> ADDRESS <i>Likeston Mo</i>			
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH <i>later</i>	
<p>*This does not mean the mode of dying, such as heart failure, asthemia, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Spine Fracture</i>							
		ANTECEDENT CAUSES							
		MORBID CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (a) STALLING 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.							

19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT SUCIDE HOMICIDE (Specify) <i>Accident</i>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Highway 66 near Likeston</i>			21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <i>Likeston - Scott Mo.</i>	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>11-11-56 2:50 P.M.</i>			21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>Wheel and Collision</i>		
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22. I hereby certify that I attended the deceased from *11-11*, 19*56*, to *11-11*, 19*56*, that I last saw the deceased alive on *11-11*, 19*56*, and that death occurred at *5:20 P.M.*, from the causes and on the date stated above.

23a. SIGNATURE <i>A. M. Farris M.D.</i> (Degree or title)		23b. ADDRESS <i>Marion, Mo.</i>		23c. DATE SIGNED <i>11-13-56</i>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		24b. DATE <i>11-14-56</i>		24c. NAME OF CEMETERY OR CREMATORY <i>Garden of Memories Likeston, Mo.</i>		24d. LOCATION (City, town, or county) (State) _____	
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DATE REC'D BY LOCAL REG. <i>11-14-56</i>		REGISTRAR'S SIGNATURE <i>Mrs. Ella Farris</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Alvin H. Jones</i> ADDRESS <i>Likeston Mo.</i>	
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(Licensed Embalmer's Statement on Reverse Side)

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

+290

DATE RECEIVED NOV 19 1956

SCOTT CO. HEALTH DEPT.

CO. FILE No. 1156-243

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 Edwin W. G. Kle.....

Licensed Embalmer No. 4000.....

P. O. Address Charleston, S.C......

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.