

FILED JAN 25 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2693

STATE FILE NUMBER

318

1003

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 69

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, give TOWNSHIP only) Inside Limits OR TOWN S. Louis, Mo. Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) Length of stay in lb HOSPITAL OR INSTITUTION 0/ 5427 Itaska		d. STREET ADDRESS (If outside, give location) Reside on Farm R/4 5427 Itaska Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Harriet O. Farnum		4. DATE OF DEATH Month Day Year Jan. 3, 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1, 1870
9. AGE (In years last birthday) 86		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (City and state or country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME August Geren		14. MOTHER'S MAIDEN NAME Unk.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no. or unknown) (If yes, give year or dates of service) no none		16. SOCIAL SECURITY NO. unk	
17. INFORMANT St. Louis, Mo. Eldon Farnum 5438 Itaska		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>Broncho pneumonia - terminal</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Tumor of bowel with hemorrhage</u> DUE TO (c) <u>Malnutrition - cachexia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio-sclerotic heart disease with decompensation, 7 days of lung</u>			INTERVAL BETWEEN ONSET AND DEATH 2 days 5 months 5 years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2	
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 Month, Day, Year a. m. p. m.		230X	
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>8-2-56</u> to <u>1-2-57</u> and last saw her alive on <u>1-2-57</u> Death occurred at <u>510 a. m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) John Lawrence		22b. ADDRESS M.D. 3720 Winking Ave S.C. 8 Mo.	
22c. DATE SIGNED 1-4-57			
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 1-7-57	
23c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park		23d. LOCATION (City, town, or county) (State) Sappington, Mo.	
24. FUNERAL DIRECTOR ADDRESS Southern Funeral Home 6322 S. Grand Blvd., St. Louis, Mo.		25. DATE RECD. BY LOCAL REG. JAN 4 1957	
26. REGISTRAR'S SIGNATURE Carl Smith M.D. mjb			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 Questioned: - It too ill to have. I am for malnutrition

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-56
 Section, colorer, etc. must use only standard nonmercuric ink in their ink. No symptoms will be visible. AIT
 diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

Dr. John V. Lawrence
3720 Washington,
1030 to 430 p.m.

APR 2 1958

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 *David Van Fossan*.....

Licensed Embalmer No. *42*.....

P. O. Address *St Louis*.....

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.