

FILED APR 22 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

11930

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3000 Registrar's No. 145

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Adair</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Kirksville</u>		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN <u>Kirksville</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Community Nursing Home #1</u>		STREET ADDRESS (If rural, give location) <u>Wabash St. 0013 0</u>	
3. NAME OF DECEASED a. (First) <u>Priscilla</u> b. (Middle) <u>A</u> c. (Last) <u>Farr</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>4 12 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>9-26-1861</u>
9. AGE (In years last birthday) <u>95</u>		IF UNDER 1 YEAR Months <u>6</u> Days <u>16</u>	IF UNDER 24 HRS. Hours <u></u> Min <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>House Keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>	11. BIRTHPLACE (City and State; foreign Country) <u>Colo Co. Ill.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13a. FATHER'S NAME <u>J. H. Landrum</u>	
13b. MOTHER'S MAIDEN NAME <u>not known</u>		14. NAME OF HUSBAND OR WIFE <u>John Farr</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>not known</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Ethel E. Naylor</u>		ADDRESS <u>LaPlata, 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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cachexia et Inanition</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic Cholecystitis</u> DUE TO (c) <u>Cholelithiasis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>		years <u></u>	
years <u></u>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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>Jan. 16, 1959</u> , to <u>April 12, 1957</u> , that I last saw the deceased alive on <u>April 12, 1957</u> , and that death occurred at <u>9:20 A.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>George H. Scheuer</u> (Degree or title) <u>D. O.</u>		23b. ADDRESS <u>Kirksville, Mo.</u>	23c. DATE SIGNED <u>4-12-57</u>
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <u>Apr. 14-57</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mc. John Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Macon Co. Mo.</u>
DATE REC'D BY LOCAL REG. <u>4-16-1957</u>	REGISTRAR'S SIGNATURE <u>Denis W. Patliff</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>D. J. Christie LaPlata Mo</u>	

WRITE PLAINLY—USING UNFADEING BLACK INK—MAKE A PERMANENT RECORD 4

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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 *D. J. Christa*

Licensed Embalmer No. *1109*

P. O. Address *LuPlato St*

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.