

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18634

State File No. _____

FILED MAY 31 1957

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

BIRTH NO. 41692-51 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 4843

1. PLACE OF DEATH
a. COUNTY _____

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE Missouri COUNTY Jefferson

b. CITY OR TOWN St. Louis, Missouri c. LENGTH OF STAY (in this place) 17 mo.

c. CITY OR TOWN House Springs d. RESIDENCE WITHIN LIMITS OF A CITY OR INCORPORATED TOWN? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Children's Hospital e. STREET ADDRESS (If rural, give location) 29 Rt. #1, Box 137 0500

3. NAME OF DECEASED a. (First) Edward b. (Middle) Wayne c. (Last) Farmer

4. DATE OF DEATH (Month) (Day) (Year) 5 22 57

5. SEX Male 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH 5-7-57 9. AGE (In years last birthday) 16 IF UNDER 1 YEAR Months _____ IF UNDER 4 HRS. 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 Foreign Country) Doniphan, Missouri 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME Coy Irland Farmer 13b. MOTHER'S MAIDEN NAME Mavis Baker 14. NAME OF HUSBAND OR WIFE Single

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) _____ 16. SOCIAL SECURITY NO. None 17. INFORMANT'S SIGNATURE OR NAME Alice Tomelidge, 500 S. Kingshighway ADDRESS _____

18. CAUSE OF DEATH. Enter only one cause per line for (a), (b) and (c).
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Rt. Nephrosis - Left cystic kidney (b) Congenital heart disease (c) Septicemia, probable
II. OTHER SIGNIFICANT CONDITIONS Congenital heart disease, microphthalmia
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION 757.1 20. AUTOPSY? YES NO

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 NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from 5-21, 1957, to 5-22, 1957, that I last saw the deceased alive on 5-22, 1957, and that death occurred at 3:21 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Barbara Jones, M.D. 23b. ADDRESS St. Louis 10, 500 S. Kingshighway 23c. DATE SIGNED 5-22-57

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 24b. DATE 5-22-57 24c. NAME OF CEMETERY OR CREMATORY Local 24d. LOCATION (City, town, or county) (State) Doniphan, Mo.

DATE REC'D BY LOCAL REG. MAY 23 57 REGISTRAR'S SIGNATURE Carl Smith MD 25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe ADDRESS 4700 Washington,

no 5

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 *Robert M. Murray*.....

Licensed Embalmer No. *3749*.....

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

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.