

FILED JUN 28 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

205193

Registration District No. 87 Primary Registration District No. 4565 Registrar's No. 6

STATE FILE NUMBER

300
1-56
0281

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>CRAWFORD</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CRAWFORD</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SULLIVAN</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>SULLIVAN</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>HUGHES FORD Rd.</u>		Length of stay in lb <u>10 YRS.</u>	STREET ADDRESS <u>HUGHES FORD ROAD</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>CECIL</u> Middle <u>MAY</u> Last <u>FARRIS</u>			4. DATE OF DEATH Month <u>JUNE</u> Day <u>24</u> Year <u>1957</u>		
5. SEX <u>FEMALE</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>MARCH 24 1902</u>	9. AGE (In years last birthday) <u>55</u> IF UNDER 1 YEAR: Month <u>3</u> Day _____ Hour _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and state or country) <u>WASHINGTON CO MO</u>	
13. FATHER'S NAME <u>EDWARD SIMMONS</u>			14. MOTHER'S MAIDEN NAME <u>ROSIE IMMEXUS</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>4</u>		17. INFORMANT Address <u>JESSE ROY FARRIS SULLIVAN, Mo</u>	
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>DIABETES MELLITUS COMA</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 WKS</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>ACUTE PYELONEPHRITIS</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>JUNE 5-57</u> to <u>JUNE 24 1957</u> and last saw her <u>alive</u> on <u>JUNE 16 1957</u> Death occurred at <u>12 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Robert M. Gray M.D.</u>			22b. ADDRESS <u>Sullivan Mo.</u>		22c. DATE SIGNED <u>June 24-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>JUNE 26 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SWAN CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>ANTHONIES MILK MO</u>
24. FUNERAL DIRECTOR <u>H. Weaton Sullivan Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>6/26/57</u>		26. REGISTRAR'S SIGNATURE <u>Ed Long</u>	

(Licensed Embalmer's Statement on Reverse Side)

FEB 2 1959

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 *J. A. Dempsey*

Licensed Embalmer No. *471*

P. O. Address *Sullivan*

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.