

FILED DEC 11 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39106
STATE FILE NUMBER

Registration District No. 13 Primary Registration District No. 5059 Registrar's No. 6

1. PLACE OF DEATH a. COUNTY <u>BARRY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>BARRY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Aurora, Rural (out)</u> <input type="checkbox"/> Inside Limits <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>AURORA, MOSE</u> <input type="checkbox"/> Inside Limits <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>10 miles S. of AURORA</u> Length of stay in lb		d. STREET ADDRESS <u>STAR Route</u> (If outside, give location) <input checked="" type="checkbox"/> Reside on Farm <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Ollie</u> Middle <u>G</u> Last <u>Farley</u>			4. DATE OF DEATH Month <u>11</u> Day <u>11</u> Year <u>57</u>			
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1-3-1891</u>	9. AGE (In years of birthday) <u>66</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rail Road</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>ENGELNEER</u>	11. BIRTHPLACE (City and state or country) <u>ARKANSAS</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>
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13a. FATHER'S NAME <u>H. T. Farley</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Gibson</u>	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 dates of service) <u>YES WW1</u>	16. SOCIAL SECURITY NO. <u>YES</u>	17. INFORMANT <u>Wm Farley, West Plains, Mo</u> Address _____
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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>Died instantly hit out medicine attention</u>		INTERVAL BETWEEN ONSET AND DEATH
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)		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.)
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20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT <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 _____
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21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
Death occurred at 7:30 2 m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Mrs P.N. Cook U.S. Health Officer Registrar</u>	22b. ADDRESS <u>Monette Mo.</u>	22c. DATE SIGNED <u>12-2-57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>11-14-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LEANN C. CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>BARRY Co. Missouri</u>
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24. FUNERAL DIRECTOR <u>MARSH FUNERAL HOME, AURORA Mo</u> ADDRESS _____	25. DATE RECD. BY LOCAL REG. <u>12-2-57</u>	26. REGISTRAR'S SIGNATURE <u>Mrs P.N. Cook</u>
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(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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BARRY COUNTY HEALTH UNIT
CASSVILLE, MO.

NO. 1257-218

DATE REC. 12-9-57

DEC 12 1957

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 *M. J. A.*....., Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Oscar S. Murrell*.....

Licensed Embalmer No. 3812.....
P. O. Address Assina, Mo......

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.