

FILED JAN 6 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

435993
STATE FILE NUMBER
Registration District No. 42 Primary Registration District No. 5131 Registrar's No. 1407

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Rural: Tremont Twp.		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN Agency Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2 miles east of Agency, Mo.		Length of stay in lb 31 years	d. STREET ADDRESS (If outside, give location) R. P. #1 Reside on Form Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Samuel Middle Farr Last Farr			4. DATE OF DEATH Month December Day 14 Year 1957
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 26, 1881
9. AGE (In years last birthday) 76		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer	11. BIRTHPLACE (City and state or country) Clinton County, Mo.
10a. KIND OF BUSINESS OR INDUSTRY farm		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Henry Clay Farr		13b. MOTHER'S MAIDEN NAME Josephene Moutray	14. NAME OF HUSBAND OR WIFE Lona Myrtle
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 496-42-2467	17. INFORMANT Mrs. Lona Farr, R.R. #1, Agency, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Hardening of arteries DUE TO (c) Right Inguinal Lymphadenopathy (Cancer)			INTERVAL BETWEEN ONSET AND DEATH minutes years
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 - SUICIDE - HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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.			
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
21. I attended the deceased from 4-1-1954 to 12-14-57 and last saw him alive on Dec 14-1957 Death occurred at 5:00p. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE G. F. Kimbell (Degree or title) MD		22b. ADDRESS 3816 Seneca Missouri	22c. DATE SIGNED 12-18-57
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 12/16/1957	23c. NAME OF CEMETERY OR CREMATORY Frazer Cemetery	23d. LOCATION (City, town, or county) (State) Buchanan County, Mo.
24. FUNERAL DIRECTOR Heaton-Bowman ADDRESS St. Joseph, Mo.		25. DATE RECD. BY LOCAL REG. Dec. 27, 1957	26. REGISTRAR'S SIGNATURE Mrs. Robert Fulton

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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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 *James P. Hawkins*

Licensed Embalmer No. *4536*

P. O. Address *319 So 10th St. York*

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.