

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006557

STATE FILE NUMBER

FILED MAR 9 1959 Registration District No. 270 Primary Registration District No. 3050 Registrar's No. 11

1. PLACE OF DEATH a. COUNTY <u>Pemiscot</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pemiscot</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Caruthersville</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Caruthersville</u> 6780 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>Airport Road</u>		Length of stay in 1b <u>59 Yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>Airport Road</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Faris</u>			4. DATE OF DEATH Month Day Year <u>February 24, 1959</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 11, 1875</u>
9. AGE (In years last birthday) <u>83</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Christney, Indiana</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Andrew Jefferson Faris</u>	
13b. MOTHER'S MAIDEN NAME <u>Sarah Latilda Smith</u>		14. NAME OF HUSBAND OR WIFE <u>X</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Lucille Fike - Caruthersville, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u>			<u>years</u>
DUE TO (c) <u>Hypertension</u>			<u>33 1/2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerotic Heart Disease</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 Month, Day, Year a.m. p.m.			
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>2-11-56</u> to <u>2-24-59</u> and last saw ^{her} _{him} alive on <u>2-23-59</u> Death occurred at <u>9:30</u> A. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Jay Cronan D.O.</u> (Degree or title)		22b. ADDRESS <u>Caruthersville Mo</u>	22c. DATE SIGNED <u>2-26-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb. 24, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Maple Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Caruthersville, Missouri</u>
24. FUNERAL DIRECTOR <u>H.S. Smith Funeral Home-C'ville, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>3-4-1959</u>	26. REGISTRAR'S SIGNATURE <u>Jessie B. Wilke</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Caution: Contaminated instruments may transmit disease. All diseases in Part I must be causally related.

Health, Welfare, Public Service

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PERMISSED COUNTY HEALTH DEPARTMENT
COURTHOUSE PHONE 79
CARITHERSVILLE, MO.

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. *This body was not embalmed*

Student
Signature of Student Embalmer

Signed *W. Denver Pike*

Licensed Embalmer No. *4484*
P. O. Address *Carithersville*
Missouri

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.