

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-009900

STATE FILE NUMBER 67

FILED APR 6 1959

Registration District No. 157 Primary Registration District No. 3028 Registrar's No.

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1. PLACE OF DEATH a. COUNTY Jasper			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jasper		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Carthage		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Carthage		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 119 N. McGregor		Length of stay in lb 50 yrs	d. STREET ADDRESS 119 N. McGregor		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Laura May Farmer			4. DATE OF DEATH Month Day Year March 25, 1959		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 30, 1875	9. AGE (In years last birthday) 83	F UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired grocer		10b. KIND OF BUSINESS OR INDUSTRY retired	11. BIRTHPLACE (City and state or country) Avilla, Missouri		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME James A. Brown		13b. MOTHER'S MAIDEN NAME Electa L. Cones		14. NAME OF HUSBAND OR WIFE Edwin T. Farmer	
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. None	17. INFORMANT Marie Murphy, 3933 N. Jackson Address Kansas City, 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) Uremia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Arteriosclerosis DUE TO (c) 4500					INTERVAL BETWEEN ONSET AND DEATH 2-3 weeks unknown
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 <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 Carthage, Missouri		COUNTY STATE
21. I attended the deceased from 5-10-59 to 2-25-59 and last saw her alive on 2-25-59 Death occurred at 10:50 P m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Shore S Patterson M D			22b. ADDRESS Carthage, Missouri		22c. DATE SIGNED 3-26-59
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 3-27-59	23c. NAME OF CEMETERY OR CREMATORY Park Cemetery		23d. LOCATION (City, town, or county) (State) Carthage, Mo.
24. FUNERAL DIRECTOR Knell Mortuary, Carthage, Mo.			25. DATE RECD. BY LOCAL REG. 3-26-59	26. REGISTRAR'S SIGNATURE E M Clinton	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 H. Knell

Licensed Embalmer No. 4459

P. O. Address Carthage, 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.