

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-022865

STATE FILE NUMBER

2-5303

FILED JUN 19 1959

Registration District No.

Primary Registration District No.

Registration No.

300
-57

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Medical Certification

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE Missouri b. COUNTY St. Louis	
b. CITY OR TOWN St. Louis		c. CITY OR TOWN Normandy 4/71	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hosp.		d. STREET ADDRESS (If outside, give location) 6014 Bermuda Dr.	
3. NAME OF DECEASED (Type or print) First Middle Last Kerry Glenn Farthing		4. DATE OF DEATH Month Day Year June 2, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1959
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nihil		11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? ---
13a. FATHER'S NAME Glenn W. Farthing		13b. MOTHER'S MAIDEN NAME Patti Mae Hill	14. NAME OF HUSBAND OR WIFE ----
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 Glenn W. Farthing, Normandy, 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) Delectosis DUE TO (b) Prematurity DUE TO (c) 762.5 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
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 6/1/59 to 6/2/59 and last saw him alive on 6/2/59 Death occurred at 1:30 pm 6/2/59 m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Edward J. Schubert, M.D.</i>		22b. ADDRESS 111 Church St	22c. DATE SIGNED 6/2/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 6-3-59	23c. NAME OF CEMETERY OR CREMATORY Memorial Garden	23d. LOCATION (City, town, or county) (State) Murray, Kentucky.
24. FUNERAL DIRECTOR ADDRESS White-Mullen Mortuary, Ferguson		25. DATE RECD. BY LOCAL REG. JUN 3 '59	26. REGISTRAR'S SIGNATURE <i>Paul Smith, M.D.</i>

mjb

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 *Reinhold J. Lohmann*

Licensed Embalmer No. *3395*

P. O. Address *Ferguson 952*

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.