

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN - 4 1960

'59 046157
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3326

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1. PLACE OF DEATH a. COUNTY St. Louis			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton		Length of stay in lb DOA	c. CITY OR TOWN Bethesda		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis County Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 9721 Bellevue Dr.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Max Middle C. Last Farmer			4. DATE OF DEATH Month December Day 12 Year 1959		
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 9/3/1908	9. AGE (last birthday) 51	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Metallurgist - Nat'l. Academy of Sciences		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Coldwater, Michigan		12. CITIZEN OF WHAT COUNTRY U.S.
13a. FATHER'S NAME Charles O. Farmer		13b. MOTHER'S MAIDEN NAME Grace Willard		14. NAME OF HUSBAND OR WIFE Dorothy F. 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. Unknown		17. INFORMANT Address Dorothy F. Farmer, 9721 Bellevue Dr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Melanoma Metastatic Cancer DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					INTERVAL BETWEEN ONSET AND DEATH
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 _____ a.m. _____ p.m. _____	Month, Day, Year				
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 _____, to _____ and last saw her/him alive on _____. Death occurred at 4:30 P.M. _____ m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) John C. Murphy MD Asst. Health Commissioner			22b. ADDRESS 801 S. Brentwood Clayton, Mo.		22c. DATE SIGNED
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12-14-59	23c. NAME OF CEMETERY OR CREMATORY LOCAL		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, Inc., 4700 Washington Blvd.			25. DATE RECD. BY LOCAL REG. 12-14-59	26. REGISTRAR'S SIGNATURE John C. Murphy M.D.	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS
NOV 7
1933

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Stanley H. Fisher

Licensed Embalmer No. 419

P. O. Address St. Louis

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.