

REGISTRATION DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-007695

FILED VS FEB 19 1960 294 Primary Registration District No. 3056 Registrar's No. 38

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Randolph				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Randolph									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Moberly		Length of stay in 1b 59 Yrs		c. CITY OR TOWN Moberly		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 432 E. Burkhardt St.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 432 E. Burkhardt St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First GUY Middle MONTIVILLE Last FARRAR			4. DATE OF DEATH Month FEB. Day 8 Year 1960										
5. SEX Male		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 6-12-1876		9. AGE (last birthday) 83		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY School Custodian				11. BIRTHPLACE (City and state or country) Missouri		12. CITIZEN OF WHAT COUNTRY USA			
13a. FATHER'S NAME Virgil Farrar				13b. MOTHER'S MAIDEN NAME Lutie Hanley				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.		17. INFORMANT Mrs. Carl Phipps				Address Moberly			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>hemorrhage from esophagus</i> <i>Myocardial infarction</i> <i>or stomach - Cause undetermined</i> <i>Arteriosclerotic coronary atherosclerosis</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Arteriosclerotic coronary atherosclerosis</i> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <i>4 hours</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Esophagitis associated with carcinoma and metastatic disease to brain</i>								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					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 <i>April 1953</i> to <i>Feb 8 1960</i> and last saw ^{her} him alive on <i>Jan 26 1960</i> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <i>Clarence Cohen M.P.</i>						22b. ADDRESS <i>317 Virginia, Moberly, Mo.</i>			22c. DATE SIGNED <i>Feb 8 60</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 10, 1960		23c. NAME OF CEMETERY OR CREMATORY Oakland			23d. LOCATION (City, town, or county) (State) Moberly Mo.						
24. FUNERAL DIRECTOR Mahan Funeral Service				ADDRESS Moberly		25. DATE RECD. BY LOCAL REG. 2-10-60		REGISTRAR'S SIGNATURE <i>Paul W. ...</i>					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FEB

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 John A. Green

Licensed Embalmer No. 3815

P. O. Address Madison, N.J.

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.