

FEDERAL BUREAU OF INVESTIGATION - DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 8 1960

-60-026393
STATE FILE NUMBER

Registration District No. 115-116 Primary Registration District No. 3020 Registrar's No. 183

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY FRANKLIN		b. CITY (If outside corporate limits, give TOWNSHIP only) WASHINGTON		a. STATE MO.		b. COUNTY FRANKLIN	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. FRANCIS HOSPITAL		Length of stay in 1b		c. CITY OR TOWN UNION		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 616 MAIN ST.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First ARTHUR		Middle HARRISON		Last FARRAR		Month AUGUST Day 2 Year 1960	
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 AUG. 27, 1890	9. AGE (last birthday) 69	IF UNDER 1 YEAR Months 11 Days 5	IF UNDER 24 HR Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHOE WORKER		10b. KIND OF BUSINESS OR INDUSTRY SHOE WORK		11. BIRTHPLACE (City and state or country) CHAMPION CITY, MO.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME RUBEN FARRAR			13b. MOTHER'S MAIDEN NAME ? MOMAN		14. NAME OF HUSBAND OR WIFE MRS. LEONA FARRAR		
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. 492-09-9745		17. INFORMANT Address MRS. LEONA FARRAR 616 E. MAIN ST. UNION MO.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Acute Hepatic Insufficiency & Coma						45-72 hrs.	
DUE TO (b) Metastatic carcinoma of the liver						unk.	
DUE TO (c) Carcinoma of head of pancreas						unk.	
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	
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		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 <u>7/25/60</u> to <u>8/2/60</u> and last saw ^{her} him alive on <u>8/2/60</u> Death occurred at <u>8:55 PM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Samuel C. Bonney M.D.				22b. ADDRESS 205 E. Elm Wash. Mo.		22c. DATE SIGNED 8/5/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE AUG. 5, 1960	23c. NAME OF CEMETERY OR CREMATORY LESLIE M.E. CEMETERY		23d. LOCATION (City, town, or county) (State) LESLIE MO		
24. FUNERAL DIRECTOR ADDRESS E. F. OLTMANN UNION, MO.				25. DATE RECD. BY LOCAL REG. 8/4/60		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AUG 9 1960

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 Ralph Ottmann

Licensed Embalmer No. 4808

P. O. Address Union, 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.