

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-020208

STATE FILE NUMBER

Registration District No. 373 Primary Registration District No. 4575 Registrar's No. 33

FILED JUN 5 1961

1. PLACE OF DEATH a. COUNTY WEBSTER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY WEBSTER	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN MARSHFIELD	Length of stay in 1b 8 HRS	c. CITY OR TOWN MARSHFIELD	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location) 525 S CHARLES	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last KEVIN THOMAS FARR			4. DATE OF DEATH Month Day Year MAY 12 1961			
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 4-26-1961	9. AGE (last birthday) IF UNDER 1 YEAR IF UNDER 24 HR Months 16 Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) MISSOURI		12. CITIZEN OF WHAT COUNTRY U.S.A	
13a. FATHER'S NAME THOMAS E. FARR		13b. MOTHER'S MAIDEN NAME EYENA RADER		14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT Address THOMAS E. FARR MARSHFIELD			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Transposition of great vessels		INTERVAL BETWEEN ONSET AND DEATH 12 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease/condition given in PART I (a) Eggs vomit bilaterally. Stenogram coli. Acquired hernias bilateral		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N: <input type="checkbox"/> Unknown	
--	--	--	--

19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 4-26-61 to 5-12-61 and last saw her/him alive on 5-11-61
Death occurred at 800 P on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) David D. Thompson M.D.	22b. ADDRESS Springfield, 600 S Blount Ave. Mo.	22c. DATE SIGNED 5-18-61
---	--	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 5-14-1961	23c. NAME OF CEMETERY OR CREMATORY MARSHFIELD	23d. LOCATION (City, town, or county) MARSHFIELD	(State) MO
---	----------------------------	--	---	-------------------

24. FUNERAL DIRECTOR ADDRESS BARBER-EDWARDS MARSHFIELD	25. DATE RECD. BY LOCAL REG. 5-22-61	26. REGISTRAR'S SIGNATURE St. Francis
---	---	--

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
SHOULD READ
BY AFFIDAVIT OF

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 Not Embalmed _____

Licensed Embalmer No. _____

P. O. Address: _____

Notes: 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.