

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-041821

STATE FILE NUMBER

Registration District No. 237 Primary Registration District No. 4356 Registrar's No. 29

AMENDED

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT MEDICAL CERTIFICATION BY AFFIDAVIT OF

FILED Nov 28 1961

1. PLACE OF DEATH
a. COUNTY **New Madrid**

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN **Parma**

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE **Okla.** b. COUNTY **Grady**

c. CITY OR TOWN **Marlow**

d. STREET ADDRESS (If outside, give location)

3. NAME OF DECEASED (Type or print) First Middle Last
Claud Madison Farmer

4. DATE OF DEATH Month Day Year
Nov. 11, 1961.

5. SEX **M**

6. COLOR OR RACE **cauc.**

7. Married Never Married
Widowed Divorced

8. DATE OF BIRTH **Dec. 15, 1892, 68 yrs.**

9. AGE (last birthday)

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
retired farmer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)
Wenddale Texas

12. CITIZEN OF WHAT COUNTRY
USA

13a. FATHER'S NAME **Charles Farmer**

13b. MOTHER'S MAIDEN NAME **Nancy Bell**

14. NAME OF HUSBAND OR WIFE
Miriam Farmer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
yes WW I

16. SOCIAL SECURITY NO.

17. INFORMANT Address
Miriam Farmer, Marlow Okla.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Poss Cardiac Insufficiency**
DUE TO (b) **History of Cardiovascular disease**
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.
 Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT SUICIDE HOMICIDE

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 NOT WHILE AT WORK

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 **Patient was dead when I arrived** and last saw him alive on **5:A:M.**
Death occurred at **5:A:M.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)
Dr. Gresh W. Hunter M.D.

22b. ADDRESS
Parma, Mo.

22c. DATE SIGNED
11/11/61

23a. BURIAL, CREMATION, REMOVAL (Specify)
burial

23b. DATE
Nov. 14, 1961

23c. NAME OF CEMETERY OR CREMATORY
Marlow Cemetery

23d. LOCATION (City, town, or county)
Marlow, Okla.

24. FUNERAL DIRECTOR ADDRESS
Watkins And Sons, Parma, Mo.

25. DATE RECD. BY LOCAL REG.
11/11/61

26. REGISTRAR'S SIGNATURE
Dr. Gresh W. Hunter, M.D.

NOV 29 1961

FEB 27 1962

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 Marsh Watkins

Licensed Embalmer No. 4717

P. O. Address Deater Mo.

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.