

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**62-008019**  
STATE FILE NUMBER

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **2407**

**FILED MAR 15 1962**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>D.O.A. City Hospital #1</b>		d. STREET ADDRESS (If outside, give location) <b>1734 Washington ave.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Porter</b> Middle <b>--</b> Last <b>Farmer</b>			4. DATE OF DEATH Month <b>February</b> Day <b>27</b> Year <b>1962</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>10-27-1898</b>	9. AGE (last birthday) <b>63</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerical</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Hotel Work</b>	11. BIRTHPLACE (City and state or country) <b>Dukedom, Tennessee</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>Richard F. Farmer</b>	13b. MOTHER'S MAIDEN NAME <b>Martha Motheral</b>	14. NAME OF HUSBAND OR WIFE <b>Millie</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>W.B. Farmer 8326 Pennsylvania ave.</b>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Punchshot wound of head: self inflicted in room</b> DUE TO (b) <b>221 of Milner Hotel, on or about Feb. 27<sup>th</sup> 1962; while</b> DUE TO (c) <b>slipping from Temporary Mental Aberration.</b>		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Suicide - 976x</b>		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 checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>See above</b>
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20c. TIME OF INJURY? Hour <b>?</b> a.m. <b>?</b> p.m. <b>2-27-62</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Hotel</b>	20f. CITY, TOWN, OR LOCATION <b>St Louis, Mo.</b>	COUNTY	STATE
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21. I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_ and last saw her/him alive on \_\_\_\_\_  
Death occurred at \_\_\_\_\_ **2:30 P.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Paul J. Simon</b>	(Degree or title) <b>Deputy Coroner</b>	22b. ADDRESS <b>1308 Clark</b>	22c. DATE SIGNED <b>3/1/62</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>3-2-1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Burial Park</b>	23d. LOCATION (City, town, or county) <b>10100 Gravois ave.</b>
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24. FUNERAL DIRECTOR <b>C. Horneimster Mortuaries</b> 781 1/2 S. Broadway	25. DATE RECD. BY LOCAL REG. <b>MAR 1 1962</b>	26. REGISTRAR'S SIGNATURE <b>Loan Smith M.D.</b>
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

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 John P. Dennehy  
Licensed Embalmer No. 4194  
P. O. Address St. Louis, 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.