

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH

County *Howell*
Township *Galberry*
City *Mountain View Mo.* (No. _____)

Registration District No. *383*
Primary Registration District No. *5534*

File No. *16387*
Registered No. *7*
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred *50* yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Male</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <i>Married</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF <i>Sada Farrar</i>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <i>Feb 3 - 1879</i>		
7. AGE YEARS <i>54</i>	MONTHS <i>2</i>	DAYS <i>29</i>
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <i>Farmer</i> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

PARENTS	9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Missouri</i>
	10. NAME OF FATHER <i>J. N. Farrar</i>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <i>Missouri</i>
	12. MAIDEN NAME OF MOTHER <i>Elizabeth Suncan</i>
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <i>Missouri</i>
14. INFORMANT (Address) <i>Hester Farrar Mountain View Mo.</i>	
15. FILED <i>5-5-33</i> <i>Genevieve F. Love</i> REGISTRAR	

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) *May 3 1933*

17. I HEREBY CERTIFY, That I attended deceased from *May* 19*33* to *5-1-33*, 19*33* that I last saw him alive on *4-20-33*, 19*33*, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Multiple neuritis complicated with cirrhosis of liver.
over work
CONTRIBUTORY (SECONDARY) (duration) _____ yrs. mos. da.

18. WHERE WAS DISEASE CONTACTED
at home.
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? *no* DATE OF _____

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Physical*
(Signed) *C. R. Trull*, M. D.
. 19 (Address) *Int. Mo.*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL <i>Belgium Park</i>	DATE OF BURIAL <i>5-3 1933</i>
20. UNDERTAKER <i>J. Suncan</i>	ADDRESS <i>Mountain View Mo.</i>

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MAY 22 1933

