

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

Do not use this space.
Final
8834
File No. _____
Registered No. 84 _____
St. _____ Ward _____

APR 1 7 1935

1. PLACE OF DEATH
County Green Registration District No. 318
Township _____ Primary Registration District No. 2001
City Springfield (No. St. Johns) St. _____ Ward _____

2. FULL NAME Elsie May Farmer
(a) Residence, No. Goodson Johnson St. Mo. Ward _____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Jessie Farmer

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mich 19-1901

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, hrs. or min.
<u>1</u>	<u>34</u>	<u>0</u>	<u>11</u>	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work house wife
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Polk Co Mo

10. NAME OF FATHER Lynn Richards

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Polk Co Mo

12. MAIDEN NAME OF MOTHER Burth Tucker

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Polk Co Mo

14. INFORMANT (Address) Jessie Farmer
Goodson Mo

15. FILED 3-31-35 Ralph Langston REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 30 1935

17. I HEREBY CERTIFY, That I attended deceased from Mar 26 1935, to Mar 30 1935, that I last saw her alive on Mar 29, 1935, and that death occurred, on the date stated above, at 2 - A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Detention of obstruction of
pregnancy
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Pregnancy 33k wh
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH: _____
DID AN OPERATION PRECEDE DEATH? Yes DATE OF Mar 24
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Chemical symptoms &
subsequent operation
(Signed) Jos. J. [unclear] M. D.
, 19 (Address) Springfield 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 Bushers Cem DATE OF BURIAL Mich 31 1935

20. UNDERTAKER Hutchison Blue Bolivar
ADDRESS _____

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.

25

MAY 19 1968

APR 14 1968

MAY 24 1935

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1. PLACE OF DEATH

County Greene
Township.....
City..... (No. St. Johns)

Registration District No. 318
Primary Registration District No. 2001

File No.....
Registered No. 84
St..... Ward)

2. FULL NAME

Elise May Farmer
(a) Residence, No..... St.,..... Ward.
(Usual place of abode)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
34 0 11

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE..... DATE..... 19

19. UNDERTAKER (ADDRESS)

20. FILED 5-29-35 Ralph H. [Signature] (Address) Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 30, 1935

22. I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19.....

I last saw him....., 19..... Death is said to have occurred on the date stated above, at..... m.

The principal cause of death and related causes of importance were as follows:

Intestinal obstruction from adhesions, the result of a previous operation 4 yrs ago
Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed)....., M. D.

(Address).....

MAY 5 6 1963

5-8834