

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.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

791

30968

Do not use this space.

REC'D OCT 12 1938

1. PLACE OF DEATH

(a) County ..... Registration District No. **1003**  
 (b) Township ..... Primary Registration District No. .... Registered No. **8405**  
 (c) City **St. Louis** (d) Street No. **St. Anthony's Hospital** St. ....  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

**Catherine Mueller Farley** **640**  
 (a) Residence, No. **34032 McKean** St. **16** (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Widowed**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF (late) **Fred Farley**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **4-5-1869**

7. AGE YEARS **69** MONTHS **5** DAYS **19** If LESS than 1 day, ..... hrs. or ..... min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **hswife**  
 9. Industry or business in which work was done, as saw mill, bank, etc. ....  
 10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation **46**

12. BIRTHPLACE (CITY OR TOWN) **St. Louis, Mo.** (STATE OR COUNTRY)

FATHER 13. NAME **Henry Haubach**

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

MOTHER 15. MAIDEN NAME **Eliza Stamm**

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

17. INFORMANT (ADDRESS) **Mrs. Elsie Lohr**  
**34032 McKean**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Memorial PK** DATE **9-27-38**

19. FUNERAL DIRECTOR (NAME) **Southern Funeral** (ADDRESS) **6322 S. Grand Blvd**

20. FILED **SEP 26 1938** **J. Bredbeck** Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **9-24-1938**

22. I HEREBY CERTIFY, That I attended deceased from **Aug 24** 1938 to **Sept 24** 1938  
 I last saw her alive on **Sept 24** 1938. 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:

**Chronic nephritis**  
**Remotely from Ears**  
 Date of onset

Name of operation **none**  
 What test confirmed diagnosis? **Spinal X-rays** Was there an autopsy? **no**

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? **none** Date of injury ..... 19.....  
 Where did injury occur? **none** (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury **none**  
 Nature of injury **none**

24. Was disease or injury in any way related to occupation of deceased? **no**  
 If so specify **B. H. Dancy** M. D.  
 (Address) **3606 E. Adams St.**

*Dr. Wilson  
3106  
2-4-*

**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, \_\_\_\_\_

*Wilson Collins*

or by \_\_\_\_\_

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed *Wilson Collins*

Licensed Embalmer No. *3887*

P. O. Address \_\_\_\_\_

**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 this body is not embalmed, above space should be left blank.**