

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

K. 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

REC'D MAR 13 1939

5011  
Do not use this space.

1. PLACE OF DEATH

(a) County ..... Registration District No. 791  
(b) Township ..... Primary Registration District No. 1003  
(c) City St. Louis (d) Street No. St. Lukes 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.

Registered No. 1704

2. PRINT FULL NAME

651  
Dr. Thomas D. Farmer  
(a) Residence, No. 6611 WASHINGTON St. NR University City, Mo  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widower</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>MARY FARMER</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>UNK.</u>		
7. AGE YEARS <u>abt 85</u>	MONTHS	DAYS
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.		
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
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Lincoln MO</u>		
13. NAME <u>Wesley Farmer</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Lincoln MO</u>		
15. MAIDEN NAME <u>Elizabeth Cannon</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Lincoln MO</u>		
17. INFORMANT (ADDRESS) <u>Blanchy Farmer</u> <u>St. Louis</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Elsterny Mo</u> DATE <u>2/19 39</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>W. B. Bradley</u> <u>Elsterny Mo</u>		
20. FILED <u>FEB 23 1939</u> <u>J. B. Bridgman</u> Local Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-18-1939

22. I HEREBY CERTIFY, That I attended deceased from Feb 13 1939, to Feb 18 1939  
I last saw him alive on Feb 18 1939. Death is said to have occurred on the date stated above, at 9:50 m.  
The principal cause of death and related causes of importance were as follows:  
Cerebral hemorrhage  
Generalized arteriosclerosis  
with arterosclerotic heart disease  
Date of onset Feb 12

Other contributory causes of importance:  
Terminal Bronchopneumonia

Name of operation ..... Date of .....  
What test confirmed diagnosis? ..... Was there an autopsy? No

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) Wesley G. Aker M. D.  
(Address) St. Lukes Hosp., St. Louis, Mo

1704  
1704

**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.....

*Not embalmed.*

Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No. *3966*

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.**