Dr. Geo. Camp

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 13 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 2420

Registration District No. 318 | Primary Registration District No. 2001 | Registrar's No. 90

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County: Greene

(b) City or town: Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1291 N. Johnston
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)

In this community ____

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Greene

(c) City or town: Springfield
(If outside city or town limits write "RURAL")

(d) Street No.: 1291 N. Johnston
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: Mike Fahrney 1650

3. (b) If veteran, name war ____

3. (c) Social Security No. ____

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Clara E. Fahrney

6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased: March (Month) 23 (Day) 1883 (Year)

8. AGE: Years 57 | Months 10 | Days 4 | If less than one day ____ hr. ____ min.

9. Birthplace: Springfield (City, town, or county) Missouri (State or foreign country)

10. Usual occupation: Retired Painter

11. Industry or business: /

MOTHER FATHER

12. Name: Dan Fahrney /

13. Birthplace: Virginia / (City, town, or county) (State or foreign country)

MOTHER

14. Maiden name: Mollie Moffitt

15. Birthplace: W. Virgini (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Clara Fahrney

(b) Address: Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan. 29 1940 (Month) (Day) (Year)

(c) Place: burial or cremation: St. Mary

18. (a) Signature of funeral director: H.H. Lohmeyer

(b) Address: Springfield, Mo. 290

19. (a) 1/29/40 (Date received local registrar) (b) Chas A. Stepp M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 27 year 1940 hour 11 minute 15 a. M.

21. I hereby certify that I attended the deceased from June, 1939, to January 27, 1940; that I last saw him alive on Jan 27, 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cardiac failure	
Due to: Cerebral hemorrhage	
Due to: Cardio-vascular - renal disease	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? ____ While at work? ____ (Specify type of place) (e) Means of injury

23. Signature: George Hull Camp (M. D. or other)

Address: Medical Arts Bldg. Date signed

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

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

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

2420
Do not use this space.

1. PLACE OF DEATH
(a) County Greene — Registration District No. 318
(b) Township — Primary Registration District No. 2001 — Registered No. 90
(c) City Springfield (d) Street No. ..... 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 Mike Fahrney
(a) Residence, No. ..... St.
(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
M	W	M

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) March 23 1883

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	56	10	4	

OCCUPATION
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)

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. FUNERAL DIRECTOR (ADDRESS)

20. FILED 3/4/40 Chas. A. George M.D. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 27, 1940

22. I HEREBY CERTIFY That I attended deceased from ....., 19.... to ....., 19.... I last saw h..... alive on ....., 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:

	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) Geo Hall Camp M.D., M. D.
(Address) Med also Bldg

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

NOTE: Every item of information should be carefully supplied. AGE should be stated in YEARS. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.