FILED SEP 5 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27605 / 3239

Registration District No. 399 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH:

(a) County: Jackson

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

(c) Name of hospital or institution: K.C. General Hospital No. 1 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 11 days (Specify whether years, months or days) In this community 47 Yrs.

2. USUAL RESIDENCE OF DECEASED:

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

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

(d) Street No.: 5019 Brooklyn (If rural, give location)

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

3. (a) PRINT FULL NAME: MARGARET FARRIS 620

3. (b) If veteran, name war: No

3. (c) Social Security No.: no

4. Sex: Fe.

5. Color or race: Wh.

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

6. (b) Name of husband or wife: John C. Farris

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

7. Birth date of deceased: Oct. 3 (Month) 1856 (Day) (Year)

8. AGE: Years 83 Months 10 Days 11 If less than one day ____ hr. ____ min.

9. Birthplace: Gasconade (City, town, or county) Mo. (State or foreign country)

10. Usual occupation: Home

11. Industry or business:

FATHER 12. Name: Pleasant F. Price

13. Birthplace: Unknown (City, town, or county) Mo. (State or foreign country)

MOTHER 14. Maiden name: Prudence Spaulding

15. Birthplace: ____ (City, town, or county) Mo. (State or foreign country)

16. (a) Informant: Homer L. Farris

(b) Address: 5013 Brooklyn Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug. 16-40 (Month) (Day) (Year)

(c) Place: burial or cremation: Floral Hills

18. (a) Signature of funeral director: Eylar Funeral Home

(b) Address: 1800 Linwood K.C. Mo.

19. (a) Aug. 16, 1940 (Date received local registrar) (b) M. M. Crouse (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 15th year 1940 hour 4 minute 20 A. M.

21. I hereby certify that I attended the deceased from 8-4-40, 19__, to 8-15-40, 19__; that I last saw her alive on 8-15-40, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death: Appendicitis, acute, with abscess and perforation

Due to: 12

Due to:

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations: Rupture appendix found at operation 8-12-40

Of autopsy:

Duration

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature: Emery R. Shore (M. D. or other)

Med. Dir. K.C. Gen. Hosp. K.C. Mo.

Address: ____ Date signed

(Licensed Embalmer's Statement on Reverse Side)

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

No. 2 10-39 7-39 K21492

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 Chas Wilks

Licensed Embalmer No. 2644

P. O. Address 1800 Linwood

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.