

N. E.—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.

OV 25 1940

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

36683
Do not use this space.

1. PLACE OF DEATH *Webster* 20
(a) County *Webster* Registration District No. *896*
(b) Township *Frank* Primary Registration District No. *6198* Registered No. *34*
(c) City _____ (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. mon. ds. (f) How long in U. S., if of foreign birth? _____ yrs. mos. ds.

2. PRINT FULL NAME *Anna Farn*
(a) Residence, No. *Marshfield* *mo* St. *R. #3*
(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 *F* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Married*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Aug 8 - 1884*

7. AGE YEARS *55* MONTHS *6* DAYS *16* If LESS than 1 day, _____ hrs. or _____ min.

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) *Kansas*

FATHER
13. NAME *Richard Mallett*
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ind.*

MOTHER
15. MAIDEN NAME *Ceridia Bayless*
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ill.*

17. INFORMANT *C. M. Farn*
(ADDRESS) *Marshfield mo*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Pleasant Hill* DATE *Feb 16 1940*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *M. Mahan Funeral Services Marshfield mo*

20. FILED *Oct. 15 1940* *Eligene Shippee* Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Feb. 14 1940*

22. I HEREBY CERTIFY, That I attended deceased from *Feb 1 - 1940* to *Feb 14 1940*
I last saw her alive on *Feb 13 1940* Death is said to have occurred on the date stated above, at *7 P. M.*
The principal cause of death and related causes of importance were as follows:
Chronic Insultation Nephritis
Date of onset _____

Other contributory causes of importance: *1701*

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) *W. F. Schwett* M. D.
(Address) *Marion mo*

RECEIVED

District Health Officer No. 61

District File Number 1140-2827

Date Filed NOV 7 1940

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 with the above constitutes grounds for revocation of license.)

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