No. 2
-9-41
X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUL 13 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

21769

State File No. 21769

Registration District No. 567 Primary Registration District No. 5767 Registrar's No. 41

1. PLACE OF DEATH:
(a) County: MISSISSIPPI
(b) City or town: WOLF ISLAND (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: EAST PRAIRIE R.F.D. 1 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ In this community 80 yrs 4 mo 4 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: MISSOURI (b) County: MISSISSIPPI 67
(c) City or town: EAST PRAIRIE R.F.D. (If outside city or town limits, write "RURAL") 0
(d) Street No.: WOLF ISLAND COMMUNITY (If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: No 0

3. (a) PRINT FULL NAME: JAMES NICHOLAS FARIS
3. (b) If veteran, name war: No
3. (c) Social Security No.: No
4. Sex: MALE
5. Color or race: WHITE
6. (a) Single, widowed, married, divorced: MARRIED
6. (b) Name of husband or wife: MRS ADA TRAVIS FARIS
6. (c) Age of husband or wife if alive: 67 years
7. Birth date of deceased: FEBRUARY (Month) 15, (Day) 1862 (Year)

8. AGE: Years 80 Months 4 Days 4 If less than one day ____ hr. ____ min.

9. Birthplace: WOLF ISLAND (City, town, or county) MISSOURI (State or foreign country)
10. Usual occupation: FARMING
11. Industry or business: FARMING
MOTHER FATHER
12. Name: JOHN CROCKETT FARIS
13. Birthplace: STATE OF TENNESSEE (City, town, or county) (State or foreign country)
14. Maiden name: MARTHA ELEANOR KERR
15. Birthplace: COLUMBUS (City, town, or county) KENTUCKY (State or foreign country)
16. (a) Informant: MISS NADINE FARIS
(b) Address: WOLF ISLAND, MO
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6-20-42 (Month) (Day) (Year)
(c) Place: burial or cremation I.O.O.F. CHARLESTON, MO
18. (a) Signature of funeral director: John T. Hunnicutt Jr.
(b) Address: CHARLESTON, MO
19. (a) 7-3-42 (Date received local registrar) (b) S. Bingman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 19 year 1942 hour 9 minute 18 A.M.

21. I hereby certify that I attended the deceased from Feb 17, 1942 to June 19, 1942 that I last saw him alive on June 18, 1942 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Hypostatic Pneumonia	4 days
Due to Ch. Myocardial insufficiency	4 mon
Due to Arteriosclerosis nephritis	
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature: William L. Davis (M. D. or other) D.V.M.
Address: Charleston Mo Date signed 6-20-42

12.71 (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 John F. Nunnelee Jr

Licensed Embalmer No. 3851

P. O. Address Charleston Mo

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, fact should be so stated above.

V. S. No. 2B
10M—8-21-41
I X29288

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21769

Registration District No. 567 Primary Registration District No. 5767 Registrar's No.

1. PLACE OF DEATH:
(a) County: Mississippi
(b) City or town: Rural.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(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 (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME James N. Faris
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Feb 15 (Month) 1862 (Day) (Year)

8. AGE: Years 80 Months 4 Days If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day
year 1942 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw h alive on 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bronchial Pneumonia	
Due to Hypostatic Pneumonia	
Due to Myocardial Insufficiency	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 107
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature William L. Dayne (M. D. or other) MD
Address Charleston, Mo. Date signed 8-15-42

SUPPLEMENTARY