V. S. No. 2
50M—5-42
Rev. 5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 15 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 11380

Registration District No. 784 Primary Registration District No. 101 Registrar's No. 685

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Louis County Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 days (Specify whether years, months or days)
In this community about 16 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County St. Louis
(c) City or town Webster Groves
(If outside city or town limits, write "RURAL")
(d) Street No. 109 E. Wellington
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Oscar Farrar
3. (b) If veteran, name war ?
3. (c) Social Security No. ?
4. Sex male
5. Color or race colored
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Mattie Farrar
6. (c) Age of husband or wife if alive 54 years
7. Birth date of deceased Nov. (Month) 21, (Day) 1890 (Year)
8. AGE: Years 52 Months 3 Days 26 If less than one day hr. min.
9. Birthplace Montgomery County (City, town, or county) Tenn. (State or foreign country)
10. Usual occupation none
11. Industry or business
MOTHER FATHER
12. Name Robert Farrar
13. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)
14. Maiden name Melissa
15. Birthplace Unknown (City, town, or county) Unknown (State or foreign country)
16. (a) Informant Mattie Farrar
(b) Address 109 N. Wellington ave
17. (a) (Burial, cremation, removal)
(b) Date thereof 3-23-43 (Month) (Day) (Year)
(c) Place: burial Father Dickson
18. (a) Signature of funeral director J. C. Lewis
(b) Address Webster Groves
19. (a) 3-27-43 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 19. year 1943 hour 12 minute :30 A.M.
21. I hereby certify that I attended the deceased from 3-0-43, 19, to 3-19-43, 19; that I last saw him alive on 3-19-43, 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral hemorrhage c hemiplegia	11 days
Due to: arterio-vascular heart disease	4 years
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy: Yes	

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 George S. Logsdon (M. D. or other) M.D.
Address St Louis County Hosp Date signed 3-20-43

(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 J C Lewis

Licensed Embalmer No. 2027

P. O. Address Webster Groves

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.