

**FULL** MAY 27 1943

Registration District No. **318**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County.....

(b) City or town Saint Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
4233 West Maffitt Avenue.  
(If not in hospital or institution, write street number or location)

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

3. (a) PRINT FULL NAME KATHRYN FARMER

3. (b) If veteran, name war --- 3. (c) Social Security No. None

4. Sex Female 5. Color or race 3 Negro 6. (a) Single, widowed, married, divorced 2 Widow

6. (b) Name of husband or wife Governor Farmer 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased December 25, 1882  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>60</u>	<u>4</u>	<u>18</u>	<u>--</u> hr. <u>--</u> min.

9. Birthplace Unavailable Tennessee  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business ---

MOTHER FATHER { 12. Name Sam Allen

13. Birthplace Unavailable 9  
(City, town, or county) (State or foreign country)

14. Maiden name Mary Unavailable

15. Birthplace Unavailable 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Buster Farmer  
(b) Address 2706 North Newstead Ave.

17. (a) Burial (b) Date thereof 5-17-43  
(Burial, cremation, or removal) (Month) (Day)

(c) Place: burial or cremation Washington Ok

18. (a) Signature of funeral director Charles J. Gates  
(b) Address 4107 Finney Avenue

19. (a) None (b) J. F. Buresh  
(Date received local registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: **000**

(a) State Missouri (b) County 17

(c) City or town Saint Louis **9 11**  
(If outside city or town limits, write "RURAL")

(d) Street No. 4233 West Maffitt Avenue  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country --- **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 13th  
year 1943 hour 9: minute 15 A. M.

21. I hereby certify that I attended the deceased from March  
1, 1943 to May 12, 1943  
that I last saw h..... alive on May 13, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis, with  
Arteriosclerosis.

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death) 93

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 S. E. Mason (M. D. or other) **0**  
Address 809 North Jefferson Date signed.....

**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.....

.....William C. McDowell....., Registered Apprentice No.....  
working under my personal supervision.

Signed William C. McDowell

Licensed Embalmer No.....2114.....

P. O. Address.....1717 North Taylor Ave.....

**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.**