

S. No. 2
M-2.43
5-17-39
X3567

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **4830**

FILED JUN 4 1943 318
Registration District No. _____

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 **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis City Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1 month and 9 days**
(Specify whether _____)

In this community _____
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____

(c) City or town **4014 Westminister Place.**
(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 **George Farris**

3. (b) If veteran, name war **None**

3. (c) Social Security No. **None**

4. Sex **Male** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Sarah Farris**

6. (c) Age of husband or wife if alive **73** years

7. Birth date of deceased **July 1, 1871**
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **22**, year **1943** hour **8:55** minute _____ AM.

21. I hereby certify that I attended the deceased from **April 13**, 19**43** to **May 22**, 19**43**; that I last saw him _____ alive on **May 22**, 19**43**; and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
71	10	21	hr. _____ min. _____

9. Birthplace **Mt Vernon Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired**

Immediate cause of death
Generalized arteriosclerosis
Hypertrophy of prostate
Obstruction

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) **12/27**

MOTHER FATHER

11. Industry or business _____

12. Name **William Farris**

13. Birthplace **Mt. Vernon Illinois**
(City, town, or county) (State or foreign country)

14. Maiden name **Dora Bailey**

15. Birthplace **Mt. Vernon Illinois**
(City, town, or county) (State or foreign country)

16. (a) Informant **Sarah Farris**

(b) Address **4014 West Minister Place.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **8/24/43**
(Month) (Day) (Year)

(c) Place: burial or cremation **Valhalla Cemetery**

18. (a) Signature of funeral director **Albert H. Hoppe, Inc**

(b) Address **4700 Washington Blvd.**

19. (a) **MAY 2** (Date received) (b) **J. F. Medek** (Registrar's signature)

PHYSICIAN

Major findings: Of operations _____

Of autopsy **refused**

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 **Drewon P. Blum** (M.D. or other) _____

Address **1515 Lafayette Avenue** Date signed **5/22/43**

4800

4800

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 *Henry M. Brammer*

Licensed Embalmer No. *4200*

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, fact should be so stated above.