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

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED JUL 8 1957

DELAYED

State File No. 21332 A

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 596

1. PLACE OF DEATH:

(a) County: Greene

(b) City or town: Springfield Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Baptist Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: Hospital - 1/2 Hr.
(Specify whether)

In this community: years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Webster

(c) City or town: RURAL
(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: ISSAC A. FARR.

3. (b) If veteran, name war:

3. (c) Social Security No.:

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife:

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

7. Birth date of deceased: May (Month) 5 (Day) 1856 (Year)

8. AGE: Years 87 Months Days 25 If less than one day hr. min.

9. Birthplace: (City, town, or county) Tenn (State or foreign country)

10. Usual occupation: FARMER.

11. Industry or business:

MOTHER FATHER

12. Name: JOHN. W. FARR.

13. Birthplace: (City, town, or county) TENN (State or foreign country)

14. Maiden name: UNKNOWN.

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

16. (a) Informant: IRA FARR.

(b) Address: Seymour Mo.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: (Month) (Day) (Year)

(c) Place: burial or cremation: Pleasent Hill Cem

18. (a) Signature of funeral director: Kelley-Ferrell.

(b) Address: Seymour, Mo.

19. (a) 7-3-57 (Date received local registrar) (b) Carta Williamson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 30 year 1943 hour 8 minute 35 P.M.

21. I hereby certify that I attended the deceased from June 30 1943 to June 30 1943 that I last saw him alive on June 30 1943 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Fracture left femur	3 hrs
Due to: thru neck	
Due to: Traumatic shock	3 hrs
Other conditions: Irreversible shock	
(Include pregnancy within 3 months of death)	
on admission	

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?
Home
(Specify type of place)

While at work? No (e) Means of injury: Fall

23. Signature: Robert Glynn (M. D. or other) MD

Address: Springfield Date signed: 7/3/43

(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 K K Kelley

Licensed Embalmer No. 3334

P. O. Address Springfield 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.