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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
NOV 6 1943

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 209

Primary Registration District No. 3043

Registrar's No. 288

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

4
3
4

1. PLACE OF DEATH:

(a) County Marion

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

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

(d) Length of stay: In hospital or institution 2 Days 0
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Florence E. Farr.

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife William W. Farr. 6. (c) Age of husband or wife if alive 53 years

7. Birth date of deceased August 31, 1891.
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

52 0 1 29 hr. min.

9. Birthplace Logansport, Indiana.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Leonard S. Hurst.

{ 13. Birthplace ? Indiana
(City, town, or county) (State or foreign country)

{ 14. Maiden name Charlotte Ross.

{ 15. Birthplace ? Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Adeline Barrett.

(b) Address 5916 Wabada Ave. St. Louis, Mo.

17. (a) Burial (b) Date thereof 10-4-1943.
(Burial, cremation, or removal) (City or town) (Day) (Year)

(c) Place: burial or cremation Bethany Cemetery

18. (a) Signature of funeral director Geol L. Pleitsch, Inc.

(b) Address 5966 Easton, Ave, St. Louis.

19. (a) 10-1-43 (b) R H Connor
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Monroe

(c) City or town Stoutsville n69
(If outside city or town limits, write "RURAL")

(d) Street No. Rural Route #2 0
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September 30th.
year 1943 hour 6 minute 30 A.M.

21. I hereby certify that I attended the deceased from Sept 5 to Sept 6 1943
that I last saw her alive on Sept 6 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to _____

Due to _____

Other conditions none 83a!
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

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)

(c) Means of injury _____

23. Signature [Signature] (M. D. or D. O.) 10/1/43

Address [Signature] Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1146

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.....

Ben E. Hoffman

Licensed Embalmer No.....

4366

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.