

BUREAU OF THE CENSUS  
FILED SEP 13 1944

State File No. \_\_\_\_\_

Registration District No. 300

Primary Registration District No. 5725

Registrar's No. 90

1. PLACE OF DEATH: Macon

(a) County Macon

(b) City or town Lebanon

(c) Name of hospital or institution: Full Street Sanatorium  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 16 mo. 20 days  
(Specify whether)

In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 53

(a) State Missouri (b) County 1

(c) City or town Lebanon  
(If outside city or town limits, write "RURAL") 2

(d) Street No. \_\_\_\_\_  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Ben D. Farrar

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 2

6. (b) Name of husband or wife Alice B Farrar

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

7. Birth date of deceased June 26 1864  
(Month) (Day) (Year)

8. AGE: 80 Years 1 Months 28 Days  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Franklin Co Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Druggist

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name R H Farrar

13. Birthplace Franklin Co Mo  
(City, town, or county) (State or foreign country)

14. Maiden name Jungman Jones

15. Birthplace Franklin Co Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Robert Jameson

(b) Address Lebanon Mo

17. (a) Lebanon Mo (b) Date thereof Aug 27 44  
(Reside, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lebanon Mo

18. (a) Signature of funeral director Albert Skunkler

(b) Address Macon Mo

19. (a) 9/6 1944 (b) Pratt Hunkler  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 24  
year 1944 hour 2 minute 25 P.M.

21. I hereby certify that I attended the deceased from April 4 1943 to Aug 24 1944  
that I last saw him alive on Aug 24 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral arterio sclerosis 20 Mos.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) 97

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)

(e) Means of injury 2

23. Signature W. H. H. D. O. (M.D. or other)

Address Macon Mo Date signed 9/27/44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 10

District File Number 9-44-1612

Date Filed SEP 12 1944

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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 Albert Skinner

Licensed Embalmer No. 751

-P. O. Address Macon 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.**