S. No. 2
M—8-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 7 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 9767

Registration District No. 137 Primary Registration District No. 4216 Registrar's No. 55

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

1. PLACE OF DEATH:
(a) County Henry Co
(b) City or town Calhoun Mo (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 25 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Henry
(c) City or town Clinton Calhoun (If outside city or town limits, write "RURAL")
(d) Street No. no No 49 (If rural, give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME VALERA J. FARRIS
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced Mar
6. (b) Name of husband or wife Frank Farris
6. (c) Age of husband or wife if alive 75 years
7. Birth date of deceased May (Month) 9 (Day) 1872 (Year)

8. AGE: Years 72 Months 9 Days 24 If less than one day hr. min.

9. Birthplace WALBURN (City, town, or county) Ill (State or foreign country)
10. Usual occupation House work
11. Industry or business

FATHER
12. Name THOMAS WATSON
13. Birthplace (City, town, or county) Ill (State or foreign country)

MOTHER
14. Maiden name Gardenhier
15. Birthplace — (City, town, or county) (State or foreign country)

16. (a) Informant Frank Farris
(b) Address Calhoun Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-4-45 (Month) (Day) (Year)
(c) Place: burial or cremation Bethelham Cem
18. (a) Signature of funeral director Cornelius Peck
(b) Address Clinton Mo
19. (a) Mar 6, 1945 (Date received local registrar) (b) Ivy Kitchen (Registrar's signature) Dep

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 2 year 1945 hour 11 minute 4 M.
21. I hereby certify that I attended the deceased from Mar 1, 1945 to Mar 2, 1945
that I last saw her alive on Mar 1, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death — Myocarditis acute following apoplexy — Duration
Due to Hypertension
Due to & arteriosclerosis
Other conditions (Include pregnancy within 3 months of death)
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Gus L. Megee (M. D. or other)
Address Clinton Mo Date signed Mar 3

1591

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 7
3-45-261
Date Filed 4-6-45

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: J. E. Consolia

Licensed Embalmer No. 1891

P. O. Address Clinton 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.