

S. No. 2
OM-2-48
v. 5-11-50
K33697

20509 ✓

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 154

FILED JUN 19 1945
Registration District No. 178

Primary Registration District No. 5568

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

1000

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:
1803 Arlington
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
In this community 50 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 1803 Arlington
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME FRED DELOS FARR

3. (b) If veteran, name war none

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 1
year 1945 hour 6 minute 10 A.M.

21. I hereby certify that I attended the deceased from _____, 19____ to time of death,
that I last saw him alive on May 25, 1945
and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced, married

6. (b) Name of husband or wife Edith Farr 6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased October 13 1885
(Month) (Day) (Year)

Immediate cause of death
Coronary Occlusion
3rd or 4th attack

Due to _____

Due to _____

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

59 7 18 hr. _____ min.

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

9. Birthplace Parsons Kansas
(City, town, or county) (State or foreign country)

10. Usual occupation Druggist

11. Industry or business Savemore Drug

12. Name John Farr

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

14. Maiden name Aminta Iveral

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

16. (a) Informant Edith Farr
(b) Address 1803 Arlington

17. (a) Burial (b) Date thereof 6 4 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington Cemetery

18. (a) Signature of funeral director Geo. C. Carson Funeral Home
(b) Address Independence Missouri

19. (a) 6-1-45 (b) [Signature]
(Date received local registrar) (Registrar's signature)

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature George T. [Signature] M. D. or other _____
Address Independence Date signed 6/1/45

1103

AUG 30 1945

JUL 5 1945

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 *R. K. McFarland*

Licensed Embalmer No. *4397*

P. O. Address *Independence 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.