

FILED SEP 12 1945

Registration District No. 55

Primary Registration District No. 3011

1. PLACE OF DEATH:

(a) County Carroll Co.
(b) City or town Carrollton Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Bales Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 16 mo. (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Ray 89
(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 Thomas W^{sr} Farris

3. (b) If veteran, name war _____ 3. (c) Social Security No. no

4. Sex male 5. Color or race w 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Nicholson Farris 6. (c) Age of husband or wife if alive 51 year
7. Birth date of deceased Feb. 27 1878
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
67 | 5 | 25 | _____ hr. _____ min.

9. Birthplace Sedalia Mo (City, town, or county) (State or foreign country) 0

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER

12. Name Phas Farris

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

14. Maiden name Virginia M. Collins

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

16. (a) Informant Lena DeMint

(b) Address Hardin, Mo.

17. (a) Burial (b) Date thereof 8-21-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hardin Mo

18. (a) Signature of funeral director John F. Farris

(b) Address Hardin Mo

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 19
year 1945 hour 7 minute 00 P.M.

21. I hereby certify that I attended the deceased from 8-18-45
_____ 19____ to 8-19 1945

that I last saw him alive on 8-19 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Perforated Gastric Ulcer
peritonitis

Due to Perforated Gastric Ulcer

Due to _____

Other conditions Senility
(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)
Means of injury _____

23. Signature Carrollton (M. D. or other)

Address Carrollton Date signed 8-20-45

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. 8,

District File Number.....

Date Filed 2-8-45

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 Me

..... Registered Apprentice No.....
working under my personal supervision. -

Signed John A. Kerpchild

Licensed Embalmer No. 2789

P. O. Address Hardin 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 501Registration District No. 5.5Primary Registration District No. 3011Registrar's No. 3

1. PLACE OF DEATH:

(a) County Carroll
(b) City or town Carrollton
(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 _____
years, months or days)3. (a) PRINT
FULL NAMEThomas W^m Jarvis

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Feb. 24
(Month) (Day) (Year)8. AGE: Years 67 Months 5 Days 15 If less than one day _____ hr. _____ min.9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____
13. Birthplace _____
(City, town, or county) (State or foreign country)14. Maiden name _____
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 18-20-45 (b) Mrs. Herbert Calvert
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration _____

Due to _____

Due to _____

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 sta-
tistically.

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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

S-27050