

STANDARD CERTIFICATE OF DEATH

State File No. **32652**  
Registrar's No. **4541**

FILED NOV 14 1945  
Registration District No. **149**

Primary Registration District No. **1002**

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

**1. PLACE OF DEATH:**

(a) County Jackson

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

(c) Name of hospital or institution:  
Children's Mercy Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 hrs 20 min  
(Specify whether years, months or days)

In this community 3 hrs - 20 min

**3. (a) PRINT FULL NAME** Robert Dean Farmer

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Male 5. Color or race white

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

6. (b) Name of husband or wife

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

7. Birth date of deceased: Aug 28 1945  
(Month) (Day) (Year)

**8. AGE:**

Years	Months	Days	If less than one day
	<u>2</u>	<u>4</u>	hr. ___ min.

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

10. Usual occupation infant

11. Industry or business

**MOTHER FATHER**

12. Name Ray Robert Farmer

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

14. Maiden name Bertha Mae Phillips

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

16. (a) Informant Father

(b) Address Hardin, Mo.

17. (a) Removal (b) Date thereof 11-4-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hardin Mo 4 45

18. (a) Signature of funeral director John W. Karsch

(b) Address Hadwin, Mo.

19. (a) 11-3-45 (b) Sheraldine Holmes  
(Date to received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Ray **89**

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

(d) Street No. RR 2  
(If rural, give location)

(e) Citizen of foreign country? 1 (Yes or No)

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

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Nov day 2  
year 1945 hour 3 minute 20 P. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;

and that death occurred on the date and hour stated above.

Immediate cause of death Post. Mortem

Acute passive congestion  
lungs  
submucosal hemorrhage

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

Due to large bowel  
subserosal petechial  
hemorrhage

Other conditions lung & heart

(Include pregnancy within 3 months of death)

Major findings of autopsies Malnutrition

Of autopsies 950'

**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 W. Jackson (M. D. or other)

Address \_\_\_\_\_

Date signed 11-2-45

**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 W. Kuipchild

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.**