

No. 2  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

27454

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

FILED AUG 25 1947

Registration District No. 127

Primary Registration District No. 5464

Registrar's No. 4

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Willard, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
The Family Home, R.P. Willard  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community All of his life (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Greene  
(c) City or town Willard  
(If outside city or town limits, write "RURAL")  
(d) Street No. Rural  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME John O. Farmer

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 Married

6. (b) Name of husband or wife Mrs Winnie Farmer 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased December 19, 1884  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
62 7 25 hr. min.

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

10. Usual occupation Retired Merchant

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

12. Name Oscar Farmer

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

14. Maiden name Annie Appleby

15. Birthplace Greene County, Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Winnie Farmer

(b) Address R.F.D. 2, Willard, Missouri

17. (a) burial (b) Date thereof Aug. 16, 47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wesley's Cemetery

18. (a) Signature of funeral director Greenwade Funeral Home  
(b) Address Willard, Missouri

19. (a) 8-14-1947 (b) Jama Appleby  
(Date received local registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 14  
year 1947 hour 04:00 minute \_\_\_\_\_ A. M.

21. I hereby certify that I attended the deceased from July 15, 1947 to August 14, 1947; that I last saw him alive on August 14, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death General Peritonitis Duration 16 hours  
Due to Perforated Peptic ulcer 16 hours  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
Of autopsy Perforated ulcer of stomach 117A

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? \_\_\_\_\_ Means of injury 0

23. Signature Jenneth O. O'Connell (M. D. or other) M.D.  
Address Springfield, Mo Date signed 8-14-47

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

RECEIVED

Greene County Health Office

County File Number 47-7-74

Date Filed 8/22/47

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 Mrs. E. Y. Greenwade

Licensed Embalmer No. 2095

P. O. Address Willard, Missouri.

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. SeptRegistration District No. 127Primary Registration District No. 5464Registrar's No. 4

## 1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Willard  
(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 NAMEJohn O. James3. (b) If veteran,  
name war3. (c) Social Security  
No.4. Sex M 5. Color or  
race W 6. (a) Single, widowed, married,  
divorced M6. (b) Name of husband or wife. 6. (c) Age of husband or wife if  
alive years7. Birth date of deceased Dec 19 1885  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
62 hr. min.9. Birthplace MO  
(City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

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

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene  
(c) City or town Willard  
(If outside city or town limits, write "RURAL")(d) Street No. RR 3  
(If rural, give location)

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

If yes, name country

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 24  
year 1947 hour 11 minute 4 M.21. I hereby certify that I attended the deceased from  
to

that I last saw him alive on

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

MOTHER FATHER

SUPPLEMENTARY

S-29454