

No. 2
-12-45
-5-17-39
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THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29834

State File No. _____
Registrar's No. 1216

Registration District No. 317 Primary Registration District No. 3067 3067

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

1. PLACE OF DEATH:

(a) County St. Louis,

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

(c) Name of hospital or institution:
8 Edgewood Road,
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community Life time years, months or days

3. (a) PRINT FULL NAME Charles Thruston Farrar,

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife Nancy G. Farrar, 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased August 6, 1857
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	90	0	1	_____ hr. _____ min.

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

10. Usual occupation Retired Real Estate

11. Industry or business _____

MOTHER FATHER { 12. Name John O'Fallon Farrar,

13. Birthplace St. Louis, Missouri,
(City, town, or county) (State or foreign country)

14. Maiden name Nancy Gorman,

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

16. (a) Informant Mr. Benedict Farrar,

(b) Address 8 Edgewood Rd., Ladue,

17. (a) burial (b) Date thereof 8/9/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Wagoner Mortuary,

(b) Address 4161 Lindell Bly.

19. (a) 8-11-47 (b) Carla J. Murphy
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis, 96

(c) City or town Ladue, 12
(If outside city or town limits, write "RURAL")

(d) Street No. 8 Edgewood rd., 1
(If rural, give location) 0

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

If yes, name country no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 7
year 1947 hour 7 minute 09 M.

21. I hereby certify that I attended the deceased from August 2/1947 to Aug. 7 1947
that I last saw him alive on Aug 6 1947
and that death occurred on the date and hour stated above.

Immediate cause of death General arteriosclerosis

Due to _____

Due to 97

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? _____

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

23. Signature Anthony B. Day (M. D. or other) _____
Address 3700 Washington Date signed 8.5.47

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 *Neville P. Prohvetter*

Licensed Embalmer No. *3696*

P. O. Address *4161 Lindell*

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.