

No. 2  
-12-45  
-17-39  
X 47070

FILED DEC 29 1947

State File No. ....

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 1496

1. PLACE OF DEATH:

(a) County Worth

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

(c) Name of hospital or institution State Hospital # 2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 yrs 9 mo 28 days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Clay

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

(d) Street No. Keosauqua mo  
(If rural, give location)

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

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

3. (a) PRINT FULL NAME Mary F. Farner

3. (b) If veteran, name war nil

3. (c) Social Security No. Not given

4. Sex Female 5. Color or race White

(a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Do not know

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

7. Birth date of deceased April 21 1865  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 19  
year 1947 hour 12 minute 15 P.M.

21. I hereby certify that I attended the deceased from Jan 1st 1947 to 12-19 1947  
that I last saw h. or alive on 12-19 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of the throat Duration 1 yr

Due to Arteriosclerosis

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 statistically.

8. AGE: Years 83 Months 7 Days 28 hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Practical Nurse

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

12. Name J. A. Harmon

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

14. Maiden name Sarah Oder

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

16. (a) Informant Claud A Farmer

(b) Address R. 70, Keosauqua

17. (a) Autopsy (b) Date thereof Dec 19 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Keosauqua mo

18. (a) Signature of funeral director Stoney Funeral Home

(b) Address St Joseph mo

19. (a) 12-23-47 (b) E. L. Jenkins  
(Date received local registrar) (Registrar's signature)

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 Stoney M. Harmon (M. D. or other) \_\_\_\_\_

Address State Hospital # 2 Date signed 12/19/47

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

MOTHER FATHER

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.....

Charles M. Harman, Registered Apprentice No. 450  
working under my personal supervision.

Signed.....

John Roy Stamey  
Licensed Embalmer No. 2435

P. O. Address..... St. Joseph

**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.