

FILED APR 1 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2484

10697

BIRTH NO. #94456 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 2484

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Michigan		b. COUNTY 177			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN) St. Louis, Mo.		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) 20 Detroit			
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1		d. STREET ADDRESS (If rural, give location) 1525 Third St., 2					
3. NAME OF DECEASED (Type or Print) a. (First) FARRIS		b. (Middle) STEPHENS		c. (Last)			
4. DATE OF DEATH MARCH 8th, 1949		5. SEX male		6. COLOR OR RACE white			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) unknown		8. DATE OF BIRTH Sept. 15th ?		9. AGE (In years last birthday) 62?			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) unknown 9			
12. CITIZEN OF WHAT COUNTRY? UNKNOWN		13a. FATHER'S NAME unknown		13b. MOTHER'S MAIDEN NAME unknown			
14. NAME OF HUSBAND OR WIFE UNKNOWN		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. UNKNOWN			
17. INFORMANT'S SIGNATURE OR NAME M.A. Renard		ADDRESS St. Louis City Hospital.					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertension				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2/7/49, 19, to 3/8/49, 19, that I last saw the deceased alive on 3/8/49, 19, and that death occurred at 10:30PM m., from the causes and on the date stated above.							
23a. SIGNATURE G. H. H. H.		(Degree or title) U		23b. ADDRESS 1615 Lafayette Ave.,		23c. DATE SIGNED 3/9/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 3-19-49		24c. NAME OF CEMETERY OR CREMATORY CALVARY		24d. LOCATION (City, town, or county) (State) ST LOUIS MO	
DATE REC'D BY LOCAL MAR 19 1949		REGISTRAR'S SIGNATURE J. B. Luster		25. FUNERAL DIRECTOR'S SIGNATURE Louellen Kelly		ADDRESS 4386 Lindell	

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300

10-48

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.....

..... Student Embalmer No.

working under my personal supervision.

Signed Ralph W Henson

Signed.....
Student Embalmer

Licensed Embalmer No. 3791

P. O. Address St. Louis, 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.