

FILED AUG 15 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24129**

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

BIRTH NO. _____		REG. DIST. NO. 229		PRIMARY REG. DIST. NO. 5809		Registrar's No. 17	
1. PLACE OF DEATH a. COUNTY Montgomery Co.				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Montgomery Co.			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Bluffton Mo. Rural Danville Twp.		c. LENGTH OF STAY (in this place) 50 yrs		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Bluffton, Mo. Rural Danville, Twp.		d. STREET ADDRESS (If rural, give location) 8700	
3. NAME OF DECEASED (Type or Print) a. (First) Robert b. (Middle) Melvin c. (Last) Farabee,				4. DATE OF DEATH (Month) (Day) (Year) July 30th 1950			
5. SEX Male		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH April 19th 1865	
9. AGE (In years last birthday) 85		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		11. BIRTHPLACE (State or foreign country) Osage Co., Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Robert Farabee,			13b. MOTHER'S MAIDEN NAME Elizabeth Brumbel,			14. NAME OF HUSBAND OR WIFE Francis Farabee,	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Paul Farabee Bluffton, Mo. RFD			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Haemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Myocarditis DUE TO (c) Interstitial Nephritis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 8 days 231A	
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) None		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 March 1, 1950 , to July 30, 1950 , that I last saw the deceased alive on July 22, 1950 , and that death occurred at 8:30 A.M. , from the causes and on the date stated above.							
23a. SIGNATURE James O. Helm MD (Degree or title)				23b. ADDRESS New Florence Mo.		23c. DATE SIGNED 8-30-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE July 31st 1950		24c. NAME OF CEMETERY OR CREMATORY Hunter Cemetery		24d. LOCATION (City, town, or county) (State) Near Americus, Mo.	
DATE REC'D BY LOCAL REG. 7-30-50		REGISTRAR'S SIGNATURE James O. Helm MD 207		25. FUNERAL DIRECTOR'S SIGNATURE Stanley G. Gable		ADDRESS Americus, Mo.	

RECEIVED
AUG 12 1950
DISTRICT HEALTH OFFICE No. 4
File No.

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

D B Baker

.....
Student Embalmer

Licensed Embalmer No. 3375

P. O. Address Americus, 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.