

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7527**

FILED MAR 11 1953

BIRTH NO.

REG. DIST. NO.

318

PRIMARY REG. DIST. NO.

1003

Registrar's No.

1710

| | | | | | |
|---|--|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY | | |
| b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN St. Louis | | c. LENGTH OF STAY (in this place) township) NEER. | c. CITY OR TOWN St. Louis | | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION DePaul Hospital | | | e. STREET ADDRESS (If rural, give location) 8 8751 Oriole Ave. 2089 | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) Richard b. (Middle) c. (Last) Farrington. | | | 4. DATE OF DEATH (Month) (Day) (Year) Feb 13 1953 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH June 25, 1893 | | 9. AGE (In years last birthday) 59 if under 1 year: Months 7 Days 19 if under 11 mos. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sports Writer | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and State or Foreign Country) Minn | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13a. FATHER'S NAME Edward Farrington. | | 13b. MOTHER'S MAIDEN NAME Catherine Roth | | 14. NAME OF HUSBAND OR WIFE Phyllis Farrington. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) Yes 1st World War | | 16. SOCIAL SECURITY NO. | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Phyllis Farrington 8751 Oriole Ave | | |
| 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, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | INTERVAL BETWEEN ONSET AND DEATH 7 days 5 yr |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) m. | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? 331X | | |
| 22. I hereby certify that I attended the deceased from June 10th 1952 to Feb 13, 1953 , that I last saw the deceased alive on Feb. 12, 1953 , and that death occurred at 2:30 P.M. , from the causes and on the date stated above. | | | | | |
| 23a. SIGNATURE N. J. Honick | | 23b. ADDRESS MO 0 8102 Riverfront Blvd | 23c. DATE SIGNED 2-13-53 | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE 2/16/53 | 24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | | 24d. LOCATION (City, town, or county) (State) St. Louis, MO. | |
| DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE FEB 13 1953 Paul Smith | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Buchholz-Koeller 5967 W. Florissant | | | |

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

MAR 30 1953

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..

Student.....
Signature of Student Embalmer

Signed *Walter G. Buehler*.....

Licensed Embalmer No. *456*.....

P. O. Address *St. Louis*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

• If this body is not embalmed, fact should be so stated above.