

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

13603

FILED APR 23 1953

BIRTH NO.		REG. DIST. NO. <u>71</u>		PRIMARY REG. DIST. NO. <u>3012</u>		Registrar's No. <u>49</u>	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission).			
a. COUNTY <u>Clay</u>				a. STATE <u>Missouri</u>		b. COUNTY <u>Ray</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Excelsior Springs</u>		c. LENGTH OF STAY (In this place) <u>6 WK</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Rural Pkly 0890</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Sharp Nursing Home</u>				d. STREET ADDRESS (If rural, give location) <u>None</u>			
3. NAME OF DECEASED			4. DATE OF DEATH			5. SEX	
a. (First) <u>JAMES</u>			b. (Middle) <u>ALEXANDER</u>			c. (Last) <u>FARRIS</u>	
(Type or Print)			Month <u>March</u> , Day <u>10</u> , Year <u>1953</u>			Male <input checked="" type="checkbox"/> Female <input type="checkbox"/>	
6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>March 31 - 1880</u>		9. AGE (In years, months, days, hours, min.) <u>72</u> <u>11</u> <u>9</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Lo-Mante, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Thomas Farris</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Tuckley</u>		14. NAME OF HUSBAND OR WIFE <u>Bliss Farris</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Edna Peppard, Lawson, Mo.</u>			
18. CAUSE OF DEATH		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
Enter only one cause per line for (a), (b), and (c)		1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Degeneration</u>				<u>8 years</u>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES					
		DUE TO (b) <u>Cerebral atrophy secondary</u>					
		DUE TO (c) <u>buttumor Cerebral thrombosis</u>					
		II. OTHER SIGNIFICANT CONDITIONS					
		Conditions contributing to the death but not related to the disease or condition causing death.					
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)		<u>3324</u>	
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 <u>4/12</u> , 19 <u>49</u> , to <u>3-10</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>3-9</u> , 19 <u>53</u> , and that death occurred at <u>4:30</u> a.m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Edna Peppard</u> (Degree or title) <u>Mo.</u>				23b. ADDRESS <u>Excelsior Springs Mo</u>		23c. DATE SIGNED <u>3/12/53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>3-9-53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		24d. LOCATION (City, town, or county) (State) <u>Sedalia Mo.</u>	
DATE REC'D BY LOCAL REG. <u>4/18/53</u>		REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Jarman-Prichard</u>		ADDRESS <u>Lawson, Mo.</u>	

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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
Student Embalmer

Signed *Lance K. Jarman*

Licensed Embalmer No. *4589*

P. O. Address *Exelior Spring 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.