

FILED OCT 4 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31555

BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 3059 Registrar's No. 295

1. PLACE OF DEATH a. COUNTY St. Francois		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Washington	
b. CITY OR TOWN Bonne Terre	c. LENGTH OF STAY (in this place)	c. CITY OR TOWN Belgrade	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION Bonne Terre Hosp.		e. STREET ADDRESS (If rural, give location) 1100 /	

3. NAME OF DECEASED (Type or Print) LAURA COLE FARMER	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) Sept-26, 1954
---	------------	-------------	-----------	---

5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Aug-8, 1880	9. AGE (In years) (last birthday) 74	if UNDER 1 YEAR Months 1	Days 18	if UNDER 24 HRS. Hour	Min.
---------------	------------------------	--	------------------------------	--------------------------------------	--------------------------	---------	-----------------------	------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Festus, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	-----------------------------------	---	-------------------------------------

13a. FATHER'S NAME Silas Puckett	13b. MOTHER'S MAIDEN NAME Bell Lucas	14. NAME OF HUSBAND OR WIFE Judson Farmer
----------------------------------	--------------------------------------	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. 499-36-3518	17. INFORMANT'S SIGNATURE OR NAME Margret Barr, Desloge, Mo	ADDRESS
---	-------------------------------------	---	---------

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) Myocardial failure due to atherosclerosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension of heart due to atherosclerosis DUE TO (c) Generalized arteriosclerosis arterial hypertension II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None		INTERVAL BETWEEN ONSET AND DEATH Several days Several years Several years
--	--	--	--

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 477X	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)	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 4/3/54, 19, to 9/26, 1954, that I last saw the deceased alive on 9/25, 1954, and that death occurred at 3:00A m., from the causes and on the date stated above.

23a. SIGNATURE Paul L. Jones MD	(Degree or title)	23b. ADDRESS Flat River, Missouri	23c. DATE SIGNED Sept. 28, 1954
---------------------------------	-------------------	-----------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sept-28-1954	24c. NAME OF CEMETERY OR CREMATORY Quaker Cemetery	24d. LOCATION (City, town, or county) (State) Quaker Mo Missouri
--	------------------------	--	---

DATE REC'D BY LOCAL REG. Sept 28, 1954	REGISTRAR'S SIGNATURE Esther Rudloff	25. FUNERAL DIRECTOR'S SIGNATURE SPARKS F. HOME	ADDRESS Flat River, Mo
--	--------------------------------------	---	------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

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 *Murphy Sparks*
Licensed Embalmer No. *4236*
P. O. Address *Had River*

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.