

FILED NOV 22 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **38715**  
**9728**

**318**

**1003**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. \_\_\_\_\_ PRIMARY REG. DIST. NO. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS</b>	c. LENGTH OF STAY (In this place)	c. CITY OR TOWN <b>ST. LOUIS</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>4177<sup>A</sup> CASTLEMAN</b>		e. STREET ADDRESS (If rural, give location) <b>4177<sup>A</sup> CASTLEMAN 2179</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Joseph.</b> b. (Middle) <b>-</b> c. (Last) <b>FARKAS</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>10-25-1954</b>
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (as wife) <b>MARRIED</b>	8. DATE OF BIRTH <b>7-22-1897</b>	9. AGE (In years) (Last birthday) <b>57</b>	10. UNDER 1 YEAR (Months) <b>3</b>	11. UNDER 12 HRS. (Hours) <b>3</b>	12. UNDER 15 MIN. (Min.)
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHIPPING CLERK</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>GROCERIES</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>HUNGARIA</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Adolph FARKAS</b>	13b. MOTHER'S MAIDEN NAME <b>NOT KNOWN</b>	14. NAME OF HUSBAND OR WIFE <b>FABIAN LAURENT FARKAS</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>NO</b>	17. INFORMANT'S SIGNATURE OR NAME <b>FABIAN FARKAS</b>	ADDRESS <b>4177<sup>A</sup> CASTLEMAN</b>
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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		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cardiac Arrest</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Coronary Artery Disease</b> DUE TO (c) <b>Coronary Sclerosis</b>		
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"/>
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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)
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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? <b>4201</b>
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22. I hereby certify that I attended the deceased from **2-27-1954** to **10-25-1954**, that I last saw the deceased alive on **10-21-1954**, and that death occurred at **7 AM**, from the causes and on the date stated above.

23a. SIGNATURE <b>Samuel S. Nelson M.D.</b>	23b. ADDRESS <b>607 N. Grand Ave</b>	23c. DATE SIGNED <b>10-26-54</b>
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24. BURIAL, CREMATION, REMOVAL <b>REMOVAL</b>	24b. DATE <b>10-27-1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>RESURRECTION</b>	24d. LOCATION (City, town, or county) (State) <b>ST. LOUIS, MO.</b>
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DATE REC'D BY LOCAL REG. <b>OCT 26 1954</b>	REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b>	FUNERAL DIRECTOR'S SIGNATURE <b>Angermuell</b>	ADDRESS <b>3819 So Grand Blvd</b>
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S.P. (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 *[Handwritten Signature]*  
Licensed Embalmer No. 4611

P. O. Address *[Handwritten Address]*

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.