

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3866**

FILED FEB 27 1956

BIRTH NO. _____ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **183**

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

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. CITY OR TOWN St. Joseph	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) 44 yrs.		e. STREET ADDRESS (If rural, give location) 5904 King Hill Ave., 01170	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Parkview at Sunnyslope 3225 South 11th Street			
3. NAME OF DECEASED (Type or Print) a. (First) BERTHA b. (Middle) _____ c. (Last) FARR			4. DATE OF DEATH (Month) (Day) (Year) February 16, 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 8, 1868
9. AGE (In years) (Month) (Day) 87		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (City and State or Foreign Country) Cleveland, Ohio
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Frank Farr
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. None	17. INFORMANT'S SIGNATURE OR NAME, ADDRESS Arthur McClintock, Rt. # 8,
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION St. Joseph, Mo.	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 2 d	
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		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) Generalized Atherosclerosis	
II. OTHER SIGNIFICANT CONDITIONS		Obesity	
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)	331X
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 Dec 27, 1955 to Feb 16, 1956 , that I last saw the deceased alive on Feb 13, 1956 , and that death occurred at 9:30 A.M. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Martina Christ, M.D.		23b. ADDRESS St. Joseph, Mo. 6106 King Hill	23c. DATE SIGNED 2-17-56
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 2-18-1956	24c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery	24d. LOCATION (City, town, or county) (State) St. Joseph, Missouri
DATE REC'D BY LOCAL REG. Feb 20, 1956	REGISTRAR'S SIGNATURE Cather M. Allison	FEDERAL DIRECTOR'S SIGNATURE John H. ... ADDRESS St. Joseph, Mo	

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, ~~only~~, Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
John E. Rupp

Licensed Embalmer No. 398

P. O. Address *St. Joseph*

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.