

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-036845
STATE FILE NUMBER

FILED OCT 21 1958 Registration District No. 155 Primary Registration District No. 3127 Registrar's No. 186

1. PLACE OF DEATH a. COUNTY Jasper			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jasper		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Webb City		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Webb City 04920		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Jane Chinn Hospital		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 1203 W. 3rd St.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Birdie Middle G. Last Farrell			4. DATE OF DEATH Month Oct. Day 14 Year 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 4, 1881	9. AGE (In years birthday) 77	IF UNDER 1 YEAR 10 Mo 10 Ds IF UNDER 24 HRS. Hours 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 country) Goshen, New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Richard Gorman		13b. MOTHER'S MAIDEN NAME Katie Kennedy		14. NAME OF HUSBAND OR WIFE	
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.	17. INFORMANT Address Mrs. Milton Piercy, St. Joseph, Mo.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Embolism middle meningeal artery					INTERVAL BETWEEN ONSET AND DEATH 4 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Diabetes					9
DUE TO (c) Gangrene of both feet					260X 10 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY STATE
21. I attended the deceased from 10-4-58 to 10-14-58 and last saw ^{her} alive on 10-3-58 Death occurred at 3:10 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Do not write title) <i>M.S. Slaughter</i> M.S. Slaughter		22b. ADDRESS Webb City, Mo.	22c. DATE SIGNED 10-14-58
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-18-58	23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery		23d. LOCATION (City, town, or county) (State) Webb City, Mo.	
24. FUNERAL DIRECTOR Johnston-Arnee-Simpson		ADDRESS Webb City	25. DATE RECD. BY LOCAL REG. 10-15-58	26. REGISTRAR'S SIGNATURE <i>Mrs. Madeline Switzer</i>	

M.S. SLAUGHTER - D.O. - USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Medical Certification

All diseases in Part I must be causally related.

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

Jack C. Simpson

Licensed Embalmer No. 4647

P. O. Address *West City, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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