

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-020390
STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 276
FILED JUN 29 1959

V. S. 300
Rev. 1-57

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Phelps</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Rolla</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>University Medical Center</u>		Length of stay in lb <u>13 days</u>	d. STREET ADDRESS (If outside, give location) <u>Route 2</u> Reside on Form Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>—</u> Last <u>Farney</u>			4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>1959</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/10/06</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	9. AGE (In years last birthday) <u>53</u> FUNDER 1 YEAR Months Days Hours Min.
11a. FATHER'S NAME <u>Charley Farney</u>		11b. MOTHER'S MAIDEN NAME <u>Maggie Nail Farney</u>	11. BIRTHPLACE (City and state or country) <u>Sligo, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		14. NAME OF HUSBAND OR WIFE <u>Ressie Farney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, (no) or unknown) (If yes, give war or dates of service) <u>(no)</u>		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT Address <u>Hospital Chart</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4-5 WEEKS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>INTERCAPILLARY GLOMERULOSCLEROSIS</u>			<u>?</u>
DUE TO (c) <u>DIABETES MELLITUS</u>			<u>SEVERAL YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>260x</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 Month, Day, Year 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 <u>6/10/59</u> to <u>6/23/59</u> and last saw him alive on <u>6/23/59</u> Death occurred at <u>6:45 p.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>J. S. Sanders</u> (Degree or title) <u>M.D.</u>		22b. ADDRESS <u>Univ of Mo. Med Center</u>	
22c. DATE SIGNED <u>6/23/59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>6/24/59</u>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <u>Rolla Missouri</u>	
24. FUNERAL DIRECTOR <u>Robert Francis Service</u>		25. DATE RECD. BY LOCAL REG. <u>June 26 1959</u>	
ADDRESS <u>Columbia, Mo.</u>		26. REGISTRAR'S SIGNATURE <u>Mrs R.E. Palmere</u>	

securing the medical certification in the specific manner required by 193.140 MoRS 1949.
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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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
Signature of Student Embalmer

Signed *Douglas P. German*

Licensed Embalmer No. *5037*

P. O. Address *Columbia*

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.