

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-026707

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 123 Primary Registration District No. 2000 Registrar's No. 1193

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED AUG 13 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Greene</u>		a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Springfield</u>		c. CITY OR TOWN <u>Springfield</u>	
Length of stay in 1b <u>40 years</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>931 N. Rogers</u>		d. STREET ADDRESS (If outside, give location) <u>931 N. Rogers</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First <u>John</u> Middle <u>Sullivan</u> Last <u>Farris</u>		Month <u>Aug.</u> Day <u>3,</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5/10/85</u>
9. AGE (last birthday) <u>77</u>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Flour mill employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Flour Mill</u>	
11. BIRTHPLACE (City and state or country) <u>Cleburne, Texas</u>		12. CITIZEN OF WHAT COUNTRY <u>Missouri</u>	
13a. FATHER'S NAME <u>Jim Farris</u>		13b. MOTHER'S MAIDEN NAME <u>Jane Vanderber</u>	
14. NAME OF HUSBAND OR WIFE <u>Edna</u>		17. INFORMANT Address <u>Edna Farris Springfield, Missouri</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>[REDACTED]</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH <u>7 years</u>
IMMEDIATE CAUSE (a) <u>Generalized Arterio sclerosis</u>			
DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>None</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <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>7-11-60</u> to <u>8-3-62</u> and last saw him alive on <u>7-5-62</u> Death occurred at: <u>11:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Albert P. Simpson, M.D.</u>		22b. ADDRESS <u>McDaniel Bldg Springfield, Mo.</u>	
22c. DATE SIGNED <u>8-10-62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8/6/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>East Lawn</u>	23d. LOCATION (City, town, or county) (State) <u>Springfield, Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Rainey's Chapel of the Ozarks</u>		25. DATE RECD. BY LOCAL REG. <u>8-10-62</u>	26. REGISTRAR'S SIGNATURE <u>Effie S. Melton</u>

USE BLACK INK OR TYPEWRITER RIBBON

Permit

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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 H D Forest

Licensed Embalmer No. 2201

P. O. Address MT Vernon MD.

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.