

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-025846

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **6203**

STATE FILE NUMBER

Registration District No. **318**

FILED JUN 24 1963

ST-30597 XC-3 857 663

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in 1b 98 DAYS		c. CITY OR TOWN ST. LOUIS Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VAH, 915 N. GRAND AVE.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 1720 OLIVE STREET Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM D. FARRAR			4. DATE OF DEATH Month Day Year 6/10/63		
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7/11/90	9. AGE (last birthday) 72	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED WAREHOUSMAN		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) PERRY COUNTY, MISSOURI, U.S.A.	
13a. FATHER'S NAME JAMES B. FARRAR		13b. MOTHER'S MAIDEN NAME MARY JANE COX		14. NAME OF HUSBAND OR WIFE IRENE FARRAR	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-1		16. SOCIAL SECURITY NO.		17. INFORMANT Address IRENE FARR (WIDOW) 5352 ARLINGTON AVE.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BILATERAL PNEUMONIA Bilateral Pneumonia TRACHEO-ESOPHAGEAL FISTULA DUE TO (b) Tracheo-Esophageal Fistula CARCINOMA OF ESOPHAGUS DUE TO (c) Carcinoma of Esophagus Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 150x					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 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 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.) VA		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. VA attended the deceased from 3/4/63 to 6/10/63 and last saw him alive on 6/10/63 Death occurred at 8:45 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Robert E. Henry M.D.			22b. ADDRESS VAH, ST. LOUIS, MO.		22c. DATE SIGNED 6/10/63
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE June 13, 63		23c. NAME OF CEMETERY OR CREMATORY National	
23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.		24. FUNERAL DIRECTOR Thomas Kutis 2906 Gravois		25. DATE RECD. BY LOCAL REG. JUN 12 1963	
26. REGISTRAR'S SIGNATURE Earl Smith, M.D.					

EDD TEO C-CA 19200-12

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 Elena Province

Licensed Embalmer No. 3403

P. O. Address 2906 grass

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.

22/01/0