DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 36256

Registration District No. 384

Primary Registration District No. 5539

Registrar's No.

1. PLACE OF DEATH:

(a) County: Howell

(b) ~~City or town~~: Rural Spring Creek Twp.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Rt. 3, West Plains, Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: No (Specify whether

In this community: 33 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Howell

(c) City or town: Rural
(If outside city or town limits, write "RURAL")

(d) Street No.: Rt. 3, West Plains, Mo.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years

3. (a) PRINT FULL NAME: May Ledbetter M cFarland 216

3. (b) If veteran, name war: ____

3. (c) Social Security No.: ____

4. Sex: Fem

5. Color or race: white

6. (a) Single, widowed, married, divorced: widow

6. (b) Name of husband or wife: Orble McFarland

6. (c) Age of husband or wife if alive: ____ years

7. Birth date of deceased: February 25, 1906
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
33	7	21	hr. ____ min.

9. Birthplace: Howell County, Missouri 0
(City, town, or county) (State or foreign country)

10. Usual occupation: Housewife 0

11. Industry or business: 0

FATHER
12. Name: Tom Ledbetter
13. Birthplace: Howell County, Missouri
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Millise Thomas
15. Birthplace: Howell County, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature: Tom Ledbetter

(b) Address: R3 West Plains Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct. 18/39 (Month) (Day) (Year)

(c) Place: burial or cremation: Blue Mound Cemetery

18. (a) Signature of funeral director: O B McClure

(b) Address: Gainesville Mo

19. (a) 10-17-39 (Date received local registrar) (b) Vida N. Simons 344 (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 16 year 1939 hour 3 minute P. M.

21. I hereby certify that I attended the deceased from 1929, 19__, to October 16, 1939, that I last saw her alive on October 5, 1939, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Intestinal Obstruction	
Due to Cancer of Liver	
Due to Cancer of Breast and Chest Wall	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations: ____
Of autopsy: ____

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify): ____

(b) Date of occurrence: ____

(c) Where did injury occur? ____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? ____ (Specify type of place)

While at work? ____ (e) Means of injury: ____

23. Signature: [illegible] (M. D. or other)

Address: West Plains Mo Date signed 10/21/39

(Licensed Embalmer's Statement on Reverse Side)

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

30M-5-17-39
Rev. 5-17-39
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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.....

....., Registered Apprentice No.....,

working under my personal supervision.

RECEIVED

District Health Officer No. 5,

District File Number 139348

Date Filed 11 8 39

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

36256
Do not use this space.

1. PLACE OF DEATH
(a) County Howell Registration District No. 384
(b) Township Spring Creek Twp Primary Registration District No. 5539 Registered No.
(c) City (d) Street No. St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME May Ledbetter McFarland
(a) Residence, No. St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
33	7	21	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 16, 1959

22. I HEREBY CERTIFY, That I attended deceased from 19 to 19
I last saw h alive on 19 Death is said to have occurred on the date stated above, at m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Intestinal Obstruction	
Cancer of liver	
Cancer of Breast and Chest walls	
Primary Carcinoma of Breast	50

Other contributory causes of importance:
Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19
Where did injury occur?
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) R. E. Hogan, M. D.
(Address) West Plains Mo

SUPPLEMENTARY

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

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