

Registration District No. 701

Primary Registration District No. _____

Registrar's No. _____

262

1. PLACE OF DEATH: 1003
 (a) County _____
 (b) City or town St. Louis
 (c) Name of hospital or institution: 5916 Enright Ave.
 (If nos in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community _____
 years, months or days)

3. (a) PRINT FULL NAME Finis J. McFarland
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife Fannie McFarland 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Oct. 1 1855
 (Month) (Day) (Year)

8. AGE: Years 84 Months 3 Days 8 If less than one day _____ hr. _____ min.

9. Birthplace Farmington Mo.
 (City, town, or county) (State or foreign country)

10. Usual occupation Transfer Man
 11. Industry or business Retired

12. Name Unknown 13. Birthplace Unknown
 (City, town, or county) (State or foreign country)

14. Maiden name Unknown 15. Birthplace Unknown
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Louis McFarland
 (b) Address 5916 Enright Ave.

17. (a) Burial (b) Date thereof 1-12-40
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Valhalla Cem.

18. (a) Signature of funeral director Drehmann-Harral
 (b) Address 1905 Union Blvd.

19. (a) JAN 10 1940 (b) _____
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County _____
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 5916 Enright Ave
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 9
 year 1940 hour 11 minute 8 A. M.

21. I hereby certify that I attended the deceased from 1935
 _____ 19____, to January 9th 1940
 that I last saw him alive on January 9th 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Anterior Chiasmatic Chronic myocarditis Obstructive jaundice
 Due to Toxic hepatitis Malignant
 Due to General senility

Other conditions Good suppurative Proliferative sinus + nodular chronic
 (Include pregnancy within 3 months of death)
 Major findings: Of operations None

Of autopsy None
 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?
 While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. J. Brudeck (M. D. or other) _____
 Address 5916 Enright Ave Date signed 1-10-40

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.

REV. 6-17-39

1-13-30
Ca 2357
630-8
Lawrence

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.

Signed Warren A. Carver

Licensed Embalmer No. ~~8~~ 3534

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.

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 262

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 262

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (Specify whether _____)
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex MALE 5. Color or race W 6. (a) Single, widowed, married, divorced and
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year
7. Birth date of deceased: (Month) _____ (Day) _____ (Year) _____

8. AGE:	Years	Months	Days	If less than one day
	<u>84</u>	<u>3</u>	<u>8</u>	hr. _____ min. _____

9. Birthplace: (City, town, or county) _____ (State or foreign country) _____

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace: (City, town, or county) _____ (State or foreign country) _____
14. Maiden name _____ (State or foreign country) _____
15. Birthplace: (City, town, or county) _____ (State or foreign country) _____

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof: (Month) (Day) (Year) _____
(Burial, cremation, or removal) _____
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) APR 3 1940 J. F. Brudak
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 9 year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him alive on _____, 19____, and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____
Due to _____
Other conditions: (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

Duration _____
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? _____

While at work? (Specify type of place) _____ (e) Means of injury _____

23. Signature J. A. Clark (M. D. or other) _____
Address _____ Date signed _____

2B
72359

MISSOURI STATE BOARD OF HEALTH STANDARD CERTIFICATE OF DEATH

State File No. 26218
Registrar's No. 262-

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No.

Primary Registration District No.

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

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ (Specify whether
years, months or days) Family

3. (a) PRINT FULL NAME Ferris J. McFurland

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) NOV 19 1940 (b) J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

20. DATE OF DEATH: Month Jan. day 9 - 40

year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerosis
Ch. Myocarditis
Obstructive jaundice
Due to Toxic hepatitis

Due to Malnutrition
Primary biliary cirrhosis
Other conditions Ch. Nephritis
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____ 46
Of autopsy _____

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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.