

NOV 2 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35366

State File No. 9102

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1004 Registrar's No. 9102

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, write RURAL and give township) OR TOWN St. Louis, Missouri	c. LENGTH OF STAY (In this place) township	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, 2239	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1		STREET ADDRESS (If rural, give location) 1820 So. 7th. St.	

3. NAME OF DECEASED (Type or Print) a. (First) MYRTLE		b. (Middle)		c. (Last) MC FARLIN		4. DATE OF DEATH (Month) (Day) (Year) OCT. 13 1951	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 2-8-1900		9. AGE (In years last birthday) 51	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hwk.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY U.S.	

13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE John Mc Farlin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Bertha Reding 921 Geyer Ave.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) <u>Arteriosclerotic heart disease</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 years</u>	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>4200</u>	

22. I hereby certify that I attended the deceased from 4-24-51, 1951, to 10-13-51, 1951, that I last saw the deceased alive on 10-13-51, 1951, and that death occurred at 10:05 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Johna. Mahre, M.D.</u>		23b. ADDRESS 1515 Lafayette Avenue		23c. DATE SIGNED 10-15-51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10-16-51		24c. NAME OF CEMETERY OR CREMATORY Concordia Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis Mo.		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. J.</u>		ADDRESS Moydell Funeral Home 1926 Allen Av.	

DATE REC'D BY LOCAL REG. OCT 15 1951 (Licensed Embalmer's Statement on Reverse Side)

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

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 me

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed

Dale J. Shannon

Licensed Embalmer No.

4533

P. O. Address

J. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HAND WRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.