

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

PLACE OF DEATH

County Clay
Township St. Louis
or
Village _____
or
City Ex Spgs (NO. Ex Spgs Sanitarium St.; _____ Ward)

Registration District No. 198 File No. 19225
Primary Registration District No. 3011 Registered No. 73

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME William G. Mr Farland

PERSONAL AND STATISTICAL PARTICULARS

2 MEDICAL CERTIFICATE OF DEATH

SEX Male COLOR OR RACE White MARRIED Married
WIDOWED OR DIVORCED _____

DATE OF DEATH 6, 19, 1913
(Month) (Day) (Year)

DATE OF BIRTH Don't know, 1868
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 9, 1913, to June 19, 1913
that I last saw him alive on June 19, 1913
and that death occurred, on the date stated above, at 4 P m.

AGE 48 yrs. _____ mos. _____ ds. IF LESS than 1 day, _____ hrs. or _____ min.?

The CAUSE OF DEATH* was as follows:
shock from gall stone operation.
12.6

OCCUPATION (a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) General Farmer

BIRTHPLACE (City or town, State or foreign country) Lansing Kansas

Contributory Gall Stones
(SECONDARY) (Duration) 3 yrs. _____ mos. _____ ds.

NAME OF FATHER Thomas M. Farland

(Signed) J. T. Bogart M. D.
6, 20, 1913 (Address) Ex Spgs

BIRTHPLACE OF FATHER (City or town, State or foreign country) Pa

MAIDEN NAME OF MOTHER Nancy Garvin

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ill

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Garvin

At place of death _____ yrs. _____ mos. 6 ds. In the State _____ yrs. _____ mos. 6 ds.

(ADDRESS) Carroll, Kans

Where was disease contracted if not at place of death? Lansing Kans
Former or usual residence _____

Filed June 20, 1913 J. T. Bogart REGISTRAR

PLACE OF BURIAL OR REMOVAL Lansing Kans DATE OF BURIAL _____ 1913
UNDERTAKER Prather & Ingers ADDRESS Ex Spgs

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.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc. of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "*Asihenia*," "*Anaemia*" (merely symptomatic), "*Atrophy*," "*Collapse*," "*Coma*," "*Convulsions*," "*Debility*" ("*Congenital*," "*Senile*," etc.), "*Dropsy*," "*Exhaustion*," "*Heart failure*," "*Haemorrhage*," "*Inanition*," "*Marasmus*," "*Old age*," "*Shock*," "*Uraemia*," "*Weakness*," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*PUERPERAL septicaemia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

PLACE OF DEATH

County

Lelay

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

Registration District No.

198

File No.

Township

or

Village

or

City

Primary Registration District No.

3011

Registered No.

73

City

Excelsior Springs, Excelsior Springs, Paritassum

(If death occurred in a hospital or institution, give its NAME instead street and number)

FULL NAME

William G. McFarland

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

COLOR OR RACE

SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word)

Satisfactory Information Supplied.

DATE OF DEATH

June 19, 1913

(Month)

(Day) (Year)

DATE OF BIRTH

Satisfactory Information Supplied.

(Month)

(Day)

(Year)

AGE

Satisfactory Information Supplied.

If LESS than
day, hrs.
or min.?

I HEREBY CERTIFY, that I attended deceased from

Satisfactory Information Supplied.

that I last saw h. alive on

and that death occurred; on the date stated above, at

The CAUSE OF DEATH* was as follows:

OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE

(City or town, State or foreign country)

NAME OF FATHER

BIRTHPLACE OF FATHER

(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER

(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Satisfactory Information Supplied.

(Informant)

(ADDRESS)

Filed

June 20, 1913 T. T. Bagarik REGISTRAR

Contributory

(SECONDARY)

(Duration) yrs. mos. ds.

(Signed)

(Duration) yrs. mos. ds.

(Address) M. D.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL

Lawrence, Kansas

DATE OF BURIAL

Don't know

UNDERTAKER

Probus & Proje Excelsior Springs

ADDRESS

Original file, date

1913

All information called for must be written on this Supplementary Certificate.

Exact statement of OCCUPATION is very important.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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52261
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