

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County Jefferson  
 Township Jefferson  
 City Jefferson (No. ....)

Died at 10 o'clock a.m.  
 Registration District No. 1587  
 Primary Registration District No. 5587

File No. 9519  
 Registered No. 2  
 St. .... Ward)

2. FULL NAME

Ila Irene McFarland

(a) Residence. No. .... St. .... Ward. ....  
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Apr-29-1911

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
16 11 23

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work at home  
 (b) General nature of industry, business, or establishment in which employed (or employer)  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Fristoe Mo  
 (STATE OR COUNTRY)

10. NAME OF FATHER W.D. McFarland

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Fristoe Mo  
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Daisy Hill

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Cooper Co - Mo.  
 (STATE OR COUNTRY)

14. INFORMANT W.D. McFarland  
 (Address) Knob Hoster Mo

FILED Mar 22 1928 Jefferson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH (MONTH, DAY AND YEAR) Mar. 22 19 28

17. I HEREBY CERTIFY That I attended deceased from Mar 21 1928 to Mar 22 1928 that I last saw h. .... alive on Mar 22 1928, and that death occurred, on the date stated above, at 1:00 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Cerebral Embolism

8 V B  
 (duration) yrs. mos. ds. 7 4 B  
 CONTRIBUTORY (SECONDARY)  
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? no DATE OF.....

WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) F.A. BlueRover, M. D.

322, 19 28 (Address) Windsor, Mo.

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Pleasant Grove Cem. DATE OF BURIAL 3/22 1928

20. UNDERTAKER C.L. Sauls ADDRESS Knob Hoster Mo

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.

