MAR 28 1930

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

Do not use this space.

5937

1. PLACE OF DEATH
County Pitts
Township La Monte
City ..... (No. ....., ... St. ..... Ward)
Registration District No. .....
Primary Registration District No. 1
File No. .....
Registered No. .....

2. FULL NAME Charley Franklin 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 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
M	W	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 28 = 1923

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
6	10	27	

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

9. BIRTHPLACE (CITY OR TOWN) Clifton City
(STATE OR COUNTRY) Mo

PARENTS
10. NAME OF FATHER Thomas McFarland
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Benton Co. Mo
12. MAIDEN NAME OF MOTHER Jewell Buffin
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Benton Co. Mo

14. INFORMANT Thomas McFarland
(Address) La Monte Mo

15. FILED Mar 27 1930 B. F. Parker
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb = 27 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 20, 1930, to Feb 27, 1930 that I last saw him alive on Feb 27, 1930 and that death occurred, on the date stated above, at 3 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
(1) Valvulous Disease
92A
130 (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) (1a) Nephritis
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) [illegible], M. D.
, 19 (Address) Knob Noster 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 Camp Grand Country
DATE OF BURIAL Mar 1 1930

20. UNDERTAKER B F Parker La Monte Mo
ADDRESS

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.