

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

Do not use this space.

**1. PLACE OF DEATH**

County **Jackson**  
Township *Law*  
City **Kansas City** (No. **Research hosp**)

Registration District No. *528*  
Primary Registration District No. *1006*

File No. **8600**  
Registered No. **1184**  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** **Nina C. McFarland**

(a) Residence, No. **1213 Lowell KCK** St. *X* Ward \_\_\_\_\_  
(Usual place of abode)  
Length of residence in city or town where death occurred yrs. mos. **3** 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) **married**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **12/8/1868**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
**63**                      **3**                      **12**

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **housework**  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. **own home**  
10. Date deceased last worked at this occupation (month and year) **3/32** 11. Total time (years) spent in this occupation **43**

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ohio**

FATHER 13. NAME **Henry Cline**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **unknown**

MOTHER 15. MAIDEN NAME **Isabell King**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ky**

17. INFORMANT **W. K. C. McFarland** (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE **Meml Park KCK** DATE **3/22** 1932

19. UNDERTAKER **Geo. H. Long** (ADDRESS) **K C K**

20. FILED *2/22* 19 *27th M M Carline* Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **3/20**, 19**32**

22. I HEREBY CERTIFY, That I attended deceased from **Mar. 14** to **Mar. 20**, 19**32**.  
I last saw h. *ev.* alive on **Mar. 19**, 19**32**. Death is said to have occurred on the date stated above, at **12:30a**.  
The principal cause of death and related causes of importance were as follows:

*Epithelioma of the larynx; Broncho pneumonia; Bilateral nephritis; Glands.*  
Other contributory causes of importance: **1**

*Broncho pneumonia; Bilateral nephritis; Cancer.*  
Name of operation *Dissection for Cancer* Date of operation *3/17/32*  
What test confirmed diagnosis? *Microscopic* Was there an autopsy? *Yes*

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_  
(Signed) *E. D. Longman M.D.* M. D.  
(Address) *1314 Princeton St. Kansas City*

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.



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

N. B.—Every item of information should be carefully filled. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE AND STATE CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

**1. PLACE OF DEATH**

County ..... Registration District No. 399  
 Township ..... Primary Registration District No. 1002  
 City X City (No. ....) St. .... Ward (No. ....)

File No. ....  
 Registered No. 1184

**2. FULL NAME**

Nina C. 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

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

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE, 19...

19. UNDERTAKER (ADDRESS)

20. FILED 3/22 1932 M. M. Cronin Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3/20, 1932

22. I HEREBY CERTIFY, That I attended deceased from

to, 19...  
 I last saw him alive on, 19... Death is said to have occurred on the day stated above, at... m.  
 The principal cause of death and related causes of importance were as follows:

*Epithelioma of the lip  
 of the mouth, upper  
 jaw - left  
 tonsil & neck glands  
 Primary in L. upper alveolar*

Other contributory causes of importance:  
*Branch pneumonia prope  
 first noticed Nov. 25, 1931. at Dallas  
 cured it, then D. C. C. Dennis  
 treated it with radium, etc.*

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? ..... Date of injury, 19...  
 Where did injury occur? ..... (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....  
 Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased?

If so, specify .....  
 (Signed) O. J. Ferguson M. D.  
 (Address) .....

SUPPLEMENTARY

5-8600

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