

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

Do not use this space.

SEP 13 1934

30580

1. PLACE OF DEATH *St. Louis*
 County *St. Louis* Registration District No. *773*
 Township *L.L.* Primary Registration District No. *6018A*
 City (No. _____) St. _____ Ward _____

File No. _____
 Registered No. *112*

2. FULL NAME *Lucy McFarland*
 (a) Residence, No. _____
 (Usual place of abode) *Franklin Ave - (County, Indiana)*
 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

MEDICAL CERTIFICATE OF DEATH

3. SEX *f* 4. COLOR OR RACE *W* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Widowed*
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Bob McFarland*
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *unknown*
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min. *66- ? ?*

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *8-3 1934*
 22. I HEREBY CERTIFY, That I attended deceased from *July 27 1934 to Aug 3 1934*
 I last saw *her* alive on *Aug 21 1934* Death is said to have occurred on the date stated above, at *6 a.m.*

OCCUPATION
 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 _____

The principal cause of death and related causes of importance were as follows:
Acute Infectious Dysentery
Acute Colitis
 Date of onset _____
 130
 120
 Other contributory causes of importance: _____

MOTHER FATHER
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *St. Louis*
 13. NAME *unknown*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *unknown*
 15. MAIDEN NAME *unknown*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *unknown*

Name of operation *Cholec* Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

17. INFORMANT *Supt. of County Infirmary*
 (ADDRESS) _____
 18. BURIAL, CREMATION, OR REMOVAL PLACE *Burdette Cem* DATE *Aug 5 1934*
 19. UNDERTAKER *Carlington and Co*
 (ADDRESS) _____
 20. FILED *Aug 3 1934* *T. J. Robinson*
 Registrar.

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) *Rappaport* M. D.
 (Address) *Franklin Ave*

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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