

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

Do not use this space.

4053

JAN 2 2 1935

1. PLACE OF DEATH

County Stoddard Registration District No. 838
Township _____ Primary Registration District No. 4509
City Dexter (No. _____ St. _____ Ward _____)

2. FULL NAME

Marcus McDonald McFarlen

(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 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Nellie Beckey McFarlen</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Apr-14-1860</u>		
7. AGE	YEARS <u>74</u>	MONTHS <u>8</u>
	DAYS <u>18</u>	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Retired farmer</u>	
	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 _____	

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan-2- 1935
22. I HEREBY CERTIFY, That I attended deceased from Dec-1- 1934, to Jan-2- 1935
I last saw h. live alive on Jan-2- 1935 Death is said to have occurred on the date stated above, at 12:29 m.
The principal cause of death and related causes of importance were as follows:

Hypostatic pneumonia Date of onset _____
Chronic myocarditis

Name of operation none Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

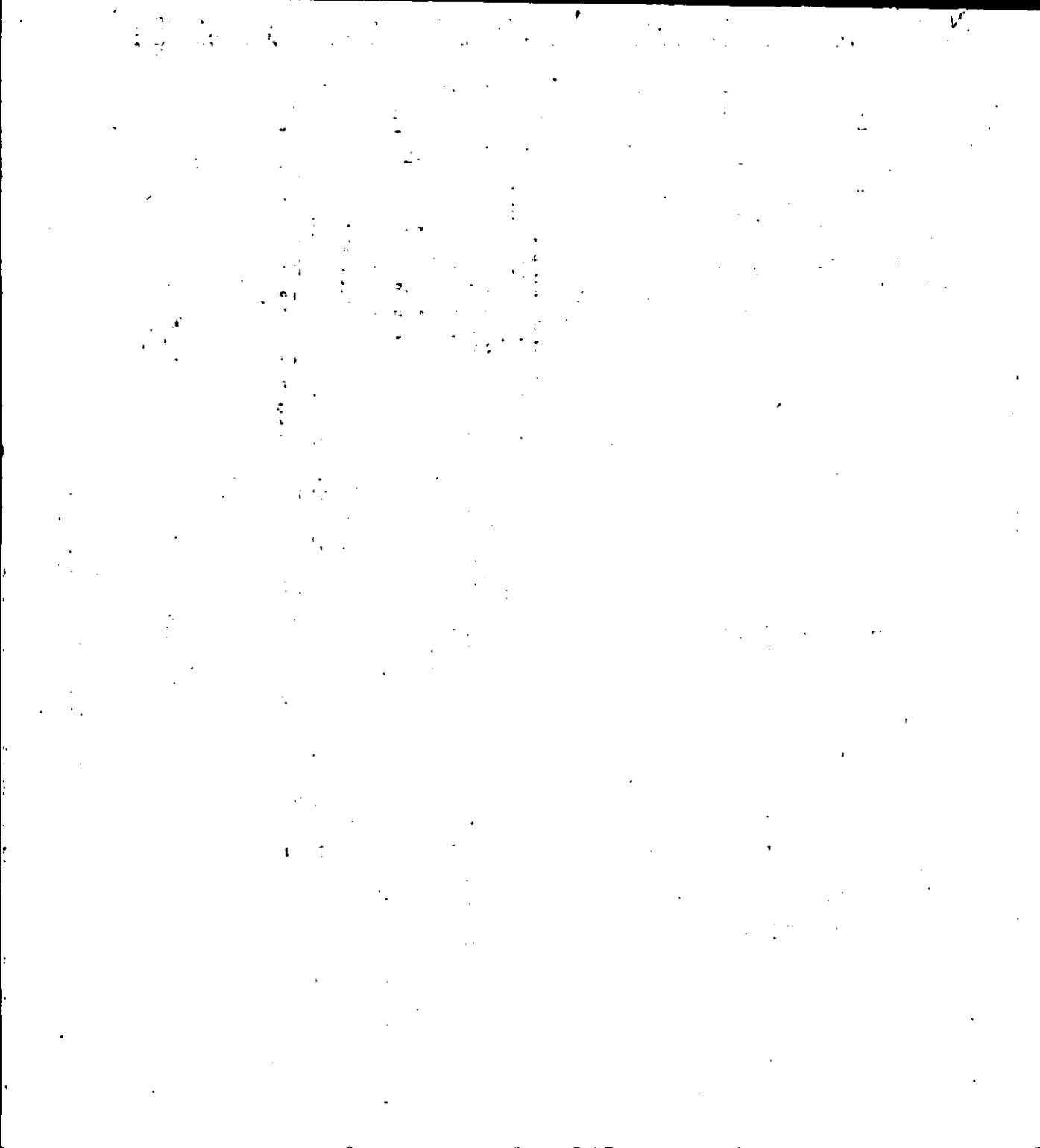
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____
(Signed) Frank Labaree, M. D.
(Address) Dexter Mo.

MOTHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ill.</u>
	13. NAME <u>Bill McFarlen</u>
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ill.</u>
	15. MAIDEN NAME <u>- ? -</u>
FATHER	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ill. - ? -</u>
	17. INFORMANT <u>J. H. Mayo</u> (ADDRESS) <u>Dexter Mo.</u>
	18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Dexter Cemetery</u> DATE <u>Jan-3-</u> 19 <u>35</u>
	19. UNDERTAKER <u>Blankenship Strickland</u> (ADDRESS) <u>Dexter Mo.</u>
20. FILED <u>1-10</u> 19 <u>35</u> <u>Alice L Norman</u> Registrar.	

N. N.—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.



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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Stoddard
Township
City Dexter (No.)

Registration District No. 838
Primary Registration District No. 4519

File No.
Registered No.
St. Ward)

2. FULL NAME

(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

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 2 - 1935

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

22. I HEREBY CERTIFY, That I attended deceased from, 19....., to, 19.....

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

I last saw, alive on, 19..... Death is said to have occurred on the date stated above, at, m.

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

The principal cause of death and related causes of importance were as follows:

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

Thyroidatic Pneumonia (Broncho) Date of onset

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

Other contributory causes of importance:
W 1935

13. NAME

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

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

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury, 19.....

15. MAIDEN NAME

Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

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

Manner of injury
Nature of injury

17. INFORMANT (ADDRESS)

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

18. BURIAL, CREMATION, OR REMOVAL

If so, specify
(Signed) Frank L. Paul, M. D.
(Address) Dexter Mo.

19. UNDERTAKER (ADDRESS)

20. FILED 1-10 1935 Alice L. Norman Registrar.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. Exact statement of OCCUPATION is very important. No premium to be paid for this certificate.

SUPPLEMENTARY

APR 23 1935

RECEIVED

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