

DEC 23 1937

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

Do not use this space.

42039

1. PLACE OF DEATH

County Madison
Township Scott
City Scott (No. _____) St. _____ Ward _____

Registration District No. 625
Primary Registration District No. 582.7

File No. _____
Registered No. 114

2. FULL NAME

Samuel Farquhar

(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 M 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 Mary E. Farquhar

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 15 - 1868

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

69 00 19

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Farmer

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) Scotland

MOTHER FATHER 13. NAME Joseph Farquhar

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

15. MAIDEN NAME Margrett Ewing

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

17. INFORMANT Sam Farquhar (ADDRESS) Clont Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Maple Lawn City DATE Nov 6 1937

19. UNDERTAKER (ADDRESS) Call of the Spirit Harmon Clont Mo

20. FILED 11-6 25 1937 Mamie E. Clardy Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 4 1937

22. I HEREBY CERTIFY, That I attended deceased from Oct 31 1937, to Nov 4 1937.

I last saw him alive on Oct 31 1937. Death is said to have occurred on the date stated above, at 5:30 P.M.

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

Cerebral Hemorrhage Date of onset 9/27

Other contributory causes of importance: Gangrene 5 days

Name of operation None Date of _____
What test confirmed diagnosis? Smear Was there an autopsy? No

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) W. E. Johnson, M. D.
(Address) Clont Mo

82a

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

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Do not use this space.

1. PLACE OF DEATH

(a) County Nodaway Registration District No. 620
 (b) Township Green Primary Registration District No. 5827 Registered No.
 (c) City (d) Street No. St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Samuel Ferguson

(a) Residence, No. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 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 Mary E Ferguson

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
69 00 19

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as 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)

FATHER 13. NAME

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

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 4 1937

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

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

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

Cerebral Hemorrhage Date of onset

Other contributory causes of importance:

Gangrene
Bedsores on legs
Obesity

Name of operation Date of operation

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?

If so, specify

(Signed) R. E. Ferguson, M. D.

(Address) Elmo Mo

SUPPLEMENTARY

