

FILED JAN 14 1943

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County St Louis, Mo.  
(b) City or town St Louis, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Missouri Baptist Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 318 (Specify whether  
In this community 318 years, months or days)

3. (a) PRINT FULL NAME William T. Mc Farland

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Elsa 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased January 1 1894  
(Month) (Day) (Year)

8. AGE: 49 Years 0 Months 0 Days If less than one day  
18 hr. 00 min.

9. Birthplace Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Chauffeur

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Francis McFarland  
13. Birthplace Ireland  
(City, town, or county) (State or foreign country)  
14. Maiden name Sarah Unknown  
15. Birthplace Ireland  
(City, town, or county) (State or foreign country)

16. (a) Informant Elsa McFarland  
(b) Address 4520 Elmbank Ave.,

17. (a) Burial (b) Date thereof 1-7-1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. John's Cemetery

18. (a) Signature of funeral director Sullivan Brothers.

(b) Address 2849 North Euclid Ave.

19. (a) JAN 5 1943 (b) J. J. [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000  
(c) City or town St. Louis 17  
(If outside city or town limits, write "RURAL") 109  
(d) Street No. 4520 Elmbank Ave.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 1003 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January Day 4th  
year 1943 hour 4 minute 15 M.

21. I hereby certify that I attended the deceased from Oct 15  
1942 to Jan 4 1943

that I last saw her alive on Jan 4 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death apoplexy Duration 22 days

Due to Central hemorrhage

Due to \_\_\_\_\_

Other conditions hypertension about 6 yrs  
(include pregnancy within 6 months of death) Yes!

Major findings: \_\_\_\_\_  
Of operations None

Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Dr. [Signature] (M. D. or other)  
Address University Club Bldg Date signed 1/5/43

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Todd.  
University Club Bldg.  
Hrs 1:00P.M.

OCT 17 1941

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*Albert Mayfield*

Licensed Embalmer No.....

*3077*

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**