

FILED DEC 3 1943

Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
K. C. General Hospital No. 10
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 13 days
(Specify whether
in this community years, months or days) 1 mo.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 815 E. 9 St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Clarence McFarland

3. (b) If veteran, name war World War #1 3. (c) Social Security No. none

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

6. (b) Name of husband or wife Velora McFarland 6. (c) Age of husband or wife if alive 37 years

7. Birth date of deceased Sept 7-1891
(Month) (Day) (Year)

8. AGE: Years 52 Months 2 Days 2 If less than one day hr. min.

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

10. Usual occupation Disabled War Veteran

11. Industry or business

12. Name Emery McFarland

13. Birthplace Adrian, Minn.
(City, town, or county) (State or foreign country)

14. Maiden name Dora Carpenter

15. Birthplace Adrian, Minn.
(City, town, or county) (State or foreign country)

16. (a) Informant Velora McFarland

(b) Address 815 E 9 St

17. (a) Removal Winner, D.D. (b) Date thereof 11-12-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Winner, D.D.

18. (a) Signature of funeral director John P. Stojan
(b) Address 4th St. N.W.

19. (a) 11-12-43 (b) D. C. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 9th
year 1943 hour 12 minute 30 A. M.

21. I hereby certify that I attended the deceased from October 27th 19 43 to November 9th 19 43
that I last saw him alive on November 9th 19 43
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Decompensation

Due to _____
Due to 950²
Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____

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? _____

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

23. Signature Dr. R. Johnson (M. D. or other) 0
Address Med. Dir. Gen'l Hosp. Date signed 11-9-43

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

MAR 1 1944

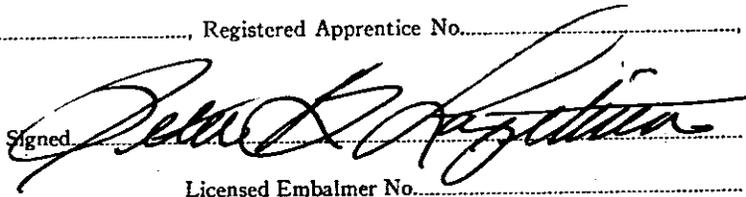


STATEMENT BY LICENSED EMBALMER

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 

Licensed Embalmer No.....

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.