

FILED NOV 10 1944
318

Registration District No. _____ Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
 (a) County _____
 (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: **City Hospital**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **1 hour.**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo.** (b) County _____
 (c) City or town **St. Louis.**
(If outside city or town limits, write "RURAL")
 (d) Street No. **821 Chestnut St.**
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Hugh McFarland.**
 (b) If veteran, name war _____
 (c) Social Security No. **498-18-3062**

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **11** day **2**
 year **44** hour **4** minute **A** M.
 21. I hereby certify that I attended the deceased from **9-6**
1944 to **11-2**, 19**44**
 that I last saw h. i. m. alive on **11-1**, 19**44**
 and that death occurred on the date and hour stated above.

4. Sex **Male** race **White**
 5. Color or **White**
 6. (a) Single, widowed, married, divorced **Divorced**
 (b) Name of husband or wife _____
 (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **Aug 7, 1897**
(Month) (Day) (Year)

Immediate cause of death **Coronary thrombosis**
 Duration **2 months**
 Due to _____
 Due to _____
 Other conditions **PH**
(Include pregnancy within 3 months of death)

8. AGE:	Years	Months	Days	If less than one day
	47	2	25	hr. _____ min. _____

9. Birthplace **St. Louis, Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Clerk.**

11. Industry or business **Orpheum Hotel.**

12. Name **Luke McFarland.**

13. Birthplace **Ireland.**
(City, town, or county) (State or foreign country)

14. Maiden name **Anna Barry.**

15. Birthplace **Ireland.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Lice Garriga.**
 (b) Address **5595 Floy Ave.**

17. (a) **Burial.** (b) Date thereof **Nov. 6, 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery.**

18. (a) Signature of funeral director **J. J. Quinn**
 (b) Address **1689 Union Blv'd.**

19. (a) **NOV 5 1944** (b) _____
(Date received local registrar) (Registrar's Signature)

Physician's Section
 Major findings: _____
 Of operations: _____
 Of autopsy: _____
 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? _____

23. Signature **R. J. Murphy** (M. D. or other) **M. D.**
 Address **634 N Grand** Date signed **11-2-44**

3201-81

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 John Ketter
Licensed Embalmer No. 3880

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.