

Registration District No. **249**

Primary Registration District No. **5845**

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County **Nodaway**
 (b) City or town **Rural - Atchison township**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
7 miles N.E. Clearmont
(If not in hospital or institution, write street number or location) **1**
 (d) Length of stay: In hospital or institution **7 years**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **James Ervin Farquhar**
3. (b) If veteran, name war **no**
3. (c) Social Security No. _____

4. Sex **male** **5. Color or race** **white**
6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Delora Etta Farquhar**
6. (c) Age of husband or wife if alive **70** years
7. Birth date of deceased **March 16, 1864**
(Month) (Day) (Year)

8. AGE: Years **80** Months **6** Days **22**
If less than one day hr. min.

9. Birthplace **Aberdeen-Shire Scotland**
(City, town, or county) (State or foreign country)

10. Usual occupation **farmer**

11. Industry or business **Joseph Farquhar**

12. Name **Joseph Farquhar**

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

14. Maiden name **Maragret Ervin**

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

16. (a) Informant **Mrs. Delora Etta Farquhar**

(b) Address **Clearmont Missouri**

17. (a) (b) Date thereof **10-9-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Burch Cemetery**

18. (a) Signature of funeral director **Wm. W. Carpenter**
(b) Address **Marionville Mo.**

19. (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z)
(Date received by local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Nodaway** **74**
 (c) City or town **Clearmont (Rural)** **0**
(If outside city or town limits, write "RURAL")
7 miles N.E. **0**
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? **yes** (Yes or No)
 If yes, name country **Scotland** **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **7**
 year **1944** hour **7** minute _____ P.M.

21. I hereby certify that I attended the deceased from **Oct 1 44 to Oct 7 44**
 that I last saw him alive on **Oct 6 1944**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Encephalitis**
 Duration **7da**

Due to **Influenza** **1wk**

Due to _____
 Other conditions **30k**
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 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?

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

23. Signature **Wm. W. Carpenter** (M. D. or other) **Wm. W. Carpenter**
 Address **Marionville Mo.** Date signed **10/9/44**

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

400

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 Clem M. Price

Licensed Embalmer No. 1822

P. O. Address Marvella Mo

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.