S. No. 2
M—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 22 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 40238

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5032

1. PLACE OF DEATH:

(a) County JACKSON

(b) City or town KANSAS (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: RESEARCH HOSPITAL (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 20 DAYS (Specify whether

In this community 18 YEARS years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State KANSAS (b) County JOHNSON

(c) City or town KANSAS CITY (If outside city or town limits, write "RURAL")

(d) Street No. 5420 FALMOUTH RD. (If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Otto C. McFARLAND.

3. (b) If veteran, name war No

3. (c) Social Security No. 486-03-7908

4. Sex MALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife MRS. FLORENCE McFARLAND

6. (c) Age of husband or wife if alive unk years

7. Birth date of deceased JULY (Month) 23 (Day) 1891 (Year)

8. AGE: Years 53 Months 4 Days 16 If less than one day hr. min.

9. Birthplace ST. LOUIS (City, town, or county) MO (State or foreign country)

10. Usual occupation EMPLOYEE

11. Industry or business S.W. BELL TEL. CO.

FATHER
12. Name LUTHER C. McFARLAND
13. Birthplace UNKNOWN (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name UNKNOWN
15. Birthplace UNKNOWN (City, town, or county) (State or foreign country)

16. (a) Informant M. L. Hilliard

(b) Address 5207 Aberdeen Rd.

17. (a) CREMATION (Burial, cremation, or removal) (b) Date thereof DEC-12-1944 (Month) (Day) (Year)

(c) Place: burial or cremation D.W. NEWCOMERS SONS

18. (a) Signature of funeral director D.W. Newcomers Sons

(b) Address 1401 BRUSH CREEK BLVD

19. (a) 12-12-44 (Date received local registrar) (b) D. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC day 9TH year 1944 hour 1 minute 45 A.M.

21. I hereby certify that I attended the deceased from Nov. 19, 1944 to 19; that I last saw him alive on 12-8, 1944; and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage P.O.

Due to Carinoma Kidney

Due to

Other conditions 52a (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy above.

Duration

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 [signature] (M. D. or other)

Address 1CC MW Date signed 12-9-44

(Licensed Embalmer's Statement on Reverse Side)

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: Emil M. Calhoun

Licensed Embalmer No. 3506

P. O. Address KC 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.