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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED FEB 8 1945**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1282  
State File No. \_\_\_\_\_  
Registrar's No. **415**

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:  
**General Hospital No. 2**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **1-13-45-1-20-45**  
(Specify whether years, months or days) **27 yr.**

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. **587 Forest**  
(If rural, give location)  
(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **ALMUS MCFARLAND**  
3. (b) If veteran, name war **None**  
3. (c) Social Security No. **None**

4. Sex **male** Color or race **Negro**  
6. (a) Single, widowed, married, divorced **single**  
6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **October 27 1913**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**33 2 24 3** hr. min.

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

10. Usual occupation **shoe-repairer**

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

MOTHER FATHER {  
12. Name **Almus McFarland**  
13. Birthplace **Mo. ( )**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Hattie Morgan**  
15. Birthplace **Mo. ( )**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Record Clerk**  
(b) Address **Gen. Hosp. #2.**

17. (a) **burial** (b) Date thereof **1/26/45**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Highland Cemetery**

18. (a) Signature of funeral director **Hickins Bros.**  
(b) Address **1729 Lydia**

19. (a) **1-26-45** (b) **N. E. Brown**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **January** day **20**  
year **1945** hour **5:50** minute **a.** M.  
21. I hereby certify that I attended the deceased from **January 13**, 1945, to **January 20**, 1945;  
that I last saw h. **im** alive on **January 20**, 1945;  
and that death occurred on the date and hour stated above.  
Immediate cause of death **Decompensation**

Due to **Rheumatic type heart disease** **4 yrs.**  
Duration

Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death) **95 lb**

PHYSICIAN  
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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature **J. P. Dineen** (M. D. or other)  
Address **Gen. Hosp #2-600 E 22** Date signed **1-23-45**

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

**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.....

*Jerome Manlove*

Licensed Embalmer No. *3994*

P. O. Address. *2503 Highland*

**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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. ....

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 415

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

1. PLACE OF DEATH:

(a) County Jackson

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

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

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

In this community.....  
years, months or days)

3. (a) PRINT FULL NAME Almus McFarland

3. (b) If veteran, name war.....

3. (c) Social Security No. 496-10-2277

4. Sex.....

5. Color or race.....

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

6. (b) Name of husband or wife.....

6. (c) Age of husband, or wife, if alive..... year.....

7. Birth date of deceased.....  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day.....  
h..... min.

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

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a) 1-26-45 (b) P. E. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(c) City or town.....  
(If outside city or town limits write "RURAL")

(d) Street No.....  
(If rural, give location)

(e) If foreign born, how long in U.S.A.?..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 20.  
Year 1945 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19..... to..... 19.....  
that I last saw h..... alive on..... 19.....  
and that death occurred on the date and hour stated above.

Immediate cause of death.....

Due to.....

Due to.....

Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations.....

Of autopsy.....

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?..... (c) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

1282