V. S. No. 2
OM—8-43
ev. 5-17-39
I—X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 12 1945

THE STATE BOARD OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. S138

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 372

**1. PLACE OF DEATH:**
(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1812 Holman St. /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 28 days
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Kansas (b) County Shawnee
(c) City or town Topeka 999
(If outside city or town limits, write "RURAL")
(d) Street No. 34
(If rural, give location)
(e) Citizen of foreign country? No. 2 (Yes or No)
If yes, name country 2

3. (a) PRINT FULL NAME Bud E. McFarland
3. (b) If veteran, name war No
3. (c) Social Security No. None
4. Sex Male 2
5. Color or race Colored 2
6. (a) Single, widowed, married, divorced Widower
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased April 13, 1872
(Month) (Day) (Year)

8. AGE: Years 72 Months 11 Days 22 If less than one day hr. min.

9. Birthplace Rockcastle Ky. /
(City, town, or county) (State or foreign country)
10. Usual occupation Barber
11. Industry or business Self
FATHER
12. Name Bud E. McFarland
13. Birthplace Kentucky /
(City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Harriet True
15. Birthplace Tenn. /
(City, town, or county) (State or foreign country)
16. (a) Informant Ethel Enoex
(b) Address 1812 Holman St.
17. (a) Removal (b) Date thereof Apr. 8, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Frankfort, Kansas
18. (a) Signature of funeral director Beatrice Gray
(b) Address 812 Pacific St.
19. (a) 4-8-45 (b) Helen I. Pickle
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month April day 5
year 1945 hour 8 minute 00 a M.
21. I hereby certify that I attended the deceased from March 26, 1945, to Apr 5, 1945
that I last saw him alive on March 26, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Mitral insufficiency — Duration: Do not know
Due to do not know
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy 92 b

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 Fenton Goodman (M. D. or other)
Address 109½ W No Ave Date signed 4-6-45

1877

(Licensed Embalmer's Statement on Reverse Side)

APR 30 1945

## 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~~ 4-5-45

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Earl a. Clark

Licensed Embalmer No. 4238

P. O. Address St Joseph 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.**