

S. No. 2  
FORM-2-43  
Rev. 5-17-39  
I X35597

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **13750**  
Registrar's No. **54**

**FILED APR 29 1946**

Registration District No. **5655**

Primary Registration District No. **5655**

1. PLACE OF DEATH:  
(a) County Lawrence  
(b) City or town Mt. Vernon TWP  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Missouri State Sanatorium  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 243 days  
In this community 243 days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County St. Francois 94  
(c) City or town Elvins 3  
(If outside city or town limits, write "RURAL") 1  
(d) Street No. 1  
(If rural, give location)  
(e) Citizen of foreign country? 1  
(Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Evelyn Ruth McFarland  
3. (b) If veteran, name war no  
3. (c) Social Security No. None known

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month March day 27th  
year 1946 hour 10:00 minute P M.

4. Sex Female 5. Color or race white  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife James W. McFarland  
6. (c) Age of husband or wife if alive 31 years  
7. Birth date of deceased July 30 1917  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 28th 1945 to March 27th 1946  
that I last saw her alive on March 27th 1946  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>28</u>	<u>7</u>	<u>28</u>	hr. _____ min. _____

Immediate cause of death: Pulmonary Tuberculosis Abt 3 yrs  
Tbc. Laryngitis & tbc. Enteritis Unknown

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

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

10. Usual occupation Housewife

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

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

Major findings: Of operations \_\_\_\_\_

MOTHER FATHER { 12. Name Fred Lewis  
13. Birthplace Unknown Illinois  
(City, town, or county) (State or foreign country)

Of autopsy 13/15  
Underline the cause to which death should be charged statistically.

14. Maiden name Wiley Ann Kegley  
15. Birthplace Unknown Indiana  
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_

16. (a) Informant F. McMichael, Record Clerk  
(b) Address Mo. State San. Mt. Vernon, Mo.

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

17. (a) Removal (b) Date thereof 5-28/46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Flat Ryon Mo

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
(Specify type of place) \_\_\_\_\_  
(e) Means of injury \_\_\_\_\_

18. (a) Signature of funeral director Flat Ryon Mo  
(b) Address speaks 2. W.

23. Signature C. A. Brasher M. D.  
Address Mount. Vernon, Mo. Date signed 3-28-46

19. (a) 3/28/46 (b) R. R. Philbrick  
(Date received local registrar) (Registrar's signature)

WRITE PLAINLY - USE UNFADING INK - MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 6,

District File Number 446-465-

Date Filed APR 17 1946

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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 Spores Fun Home

Licensed Embalmer No.....

P. O. Address Palat River

**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.