

No. 2
-5-42
-17-39
X32873

FILED NOV 21 1946

Registration District No. **128**

Primary Registration District No. **2000**

1. PLACE OF DEATH:

(a) County **GREENE**
(b) City or town **Springfield**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **EX 1029 S. Stewart**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **75 years**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Greene 39**
(c) City or town **Springfield, 2**
(If outside city or town limits, write "RURAL")
(d) Street No. **1029 S. Stewart 6**
(If rural, give location)
(e) Citizen of foreign country? **0**
(Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **MAMIE A. MCFARLAND**

3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex **Female** 5. Color or race **white**
6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **Jesse K. McFarland**
6. (c) Age of husband or wife if alive **46** years

7. Birth date of deceased **June 29, 1871**
(Month) (Day) (Year)

8. AGE: Years **75** Months **4** Days **3**
If less than one day hr. min.

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

10. Usual occupation **Domestic**

11. Industry or business

MOTHER FATHER {
12. Name **E. R. Shipley**
13. Birthplace **Unknown Pennsylvania**
(City, town, or county) (State or foreign country)
14. Maiden name **Isabel Robertson**
15. Birthplace **Springfield, Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Jesse K. McFarland**
(b) Address **1029 S. Stewart**

17. (a) **Burial** (b) Date thereof **11/4/1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **ALMA LOHMEYER FUNERAL HOME**
SPRINGFIELD, MISSOURI
(b) Address

19. (a) **11-4-46** (b) **W. H. Handley md.**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **2**
year **1946** hour **12:30 P.M.** minute **0** M.

21. I hereby certify that I attended the deceased from **Sept 20** 19**46** to **Nov 2** 19**46**
that I last saw h **el** alive on **Oct 15** 19**46**
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Occlusion 1 hr.**
Due to **Coronary Arteriosclerosis**
Due to **Diarrhea**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **131A**
Of autopsy

Duration
1 hr.
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) (Specify type of injury)

23. Signature **W. H. Handley md.** (M. D. or other) **MD.**
Address **Springfield Mo** Date signed **11-4-46**

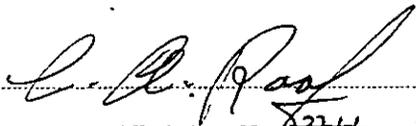
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

111

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..... 
Licensed Embalmer No. ~~8244~~ 3044
P. O. Address..... Springfield, Missouri.....

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.