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

FILED JAN 7 1947  
Registration District No. 317

Primary Registration District No. 6076

State File No. \_\_\_\_\_  
Registrar's No. 3617

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:  
Mt. St. Rose Sanitarium  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 months  
(Specify whether years, months or days)

In this community 35 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

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

(d) Street No. 7346 Gayola Ave  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ETHA BELL McFARLAND

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

3. (c) Social Security No. none

4. Sex F / 5. Color or race W

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

6. (b) Name of husband or wife Ira Arthur McFarland

6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased Aug. 27th 1874  
(Month) (Day) (Year)

8. AGE: Years 72 Months 4 Days 2  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

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

12. Name John M. Perdue

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

14. Maiden name Nancy M. Howe

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

16. (a) Informant Jennie Lovie Cates

(b) Address 7346 Gayola Pl

17. (a) Burial (b) Date thereof Jan. 2 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Hill Cemetery

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

(b) Address 6536 Clayton Rd.

19. (a) 1-2-47 (b) Ruth J Allen MD  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 29th  
year 1946 hour 11 minute 05 P.M.

21. I hereby certify that I attended the deceased from September 25, 1946 to December 29, 1946  
that I last saw he alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death For advanced Pulmonary Tuberculosis

Duration 1 year

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

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

Other conditions Generalized Arteriosclerosis  
(Include pregnancy within 3 months of death)

Arteriosclerotic Heart Disease

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature David M. Shelling Jr. (M. D. or other) M.D.

Address 4500 Olive Street Date signed 12-31-46

**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 *J. Allen Davis Jr*  
Licensed Embalmer No. *4053*  
P. O. Address *St. Louis 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.**