

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 11 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **5753**

Registration District No. **277**

Primary Registration District No. **4411**

Registrar's No. **8**

1. PLACE OF DEATH:
 (a) County **Pike**
 (b) City or town **Bowling Green Mo**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
HOME-1
(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

2. USUAL RESIDENCE OF DECEASED:
 (a) State **MO** (b) County **Pike Mo**
 (c) City or town **Bowling Green Mo**
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? **NO** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Alvie Moore McFarland**

3. (b) If veteran, name war **X** 3. (c) Social Security No. **none**

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

6. (b) Name of husband or wife **John B. McFarland** 6. (c) Age of husband or wife if **9** years
 Birth date of deceased: **Mar 1872**
(Month) (Day) (Year)

8. AGE: Years **74** Months **11** Days **27** hr. _____ min. _____
If less than one day

9. Birthplace **New Hartford Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **House wife**

11. Industry or business _____

12. Name **Linden Moore**

13. Birthplace **Linden Co Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **Harriet Jamison**

15. Birthplace **Linden Co. Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **G. A. McFarland**

(b) Address **Kansas City Mo.**

17. (a) **Burial** (b) Date thereof **Mar 9 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Wahley Mo.**

18. (a) Signature of funeral director **Grant Robinson**

(b) Address **Bowling Green Mo.**

19. (a) **3/8/47** (b) **J. B. Robinson**
(Date received by registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **3** day **7**
 year **1947** hour **7** minute **30 A.M.**

21. I hereby certify that I attended the deceased from **3-3-47**
2 19. to **3-6-47** 19. ;
 that I last saw **u** alive on **3-5-47** 19. ;
 and that death occurred on the date and hour stated above.

Immediate cause of death: **Cardiac Insufficiency** Duration 1 day

Due to **Diabetes Mellitus** yes

Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
 Of operations **61**

Of autopsy _____

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) (Means of injury)

23. Signature **J. M. Hartman** (M. D. or other) **no**

Address **Bowling Green Mo** Date signed **3-7-47**

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

MOTHER FATHER

RECEIVED
District Health Officer No. 10
District File No. 3-47-507
MAR-1-2 1947

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 *Grace M. Danforth*

Licensed Embalmer No. *2204*

P. O. Address *Bowling Green W*

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.