

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9704**

FILED APR 1 1947

Registration District No. **155** Primary Registration District No. ~~155~~ **4244** Registrar's No. **33**

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

1. PLACE OF DEATH:
 (a) County **Jasper**
 (b) City or town **Carterville**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
303 E. HANNUM
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether)
 In this community **24 yrs**
years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Jasper**
 (c) City or town **Carterville**
(If outside city or town limits, write "RURAL")
 (d) Street No. **303 E. Hannum**
(If rural, give location)
 (e) Citizen of foreign country? **NO** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **John Wm McFarland**
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
 4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Bertha Maude McFarland** 6. (c) Age of husband or wife if alive **59** years
 7. Birth date of deceased **March 7 1872**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **March** day **13** year **1947** hour **9:30** minute **AM**
 21. I hereby certify that I attended the deceased from **MCH 13; 47** 19____ to **MCH 13; 47** 19____; that I last saw h. **IM** alive on **3-13-47** 19____; and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
75	0	6	hr. _____ min. _____

Immediate cause of death **HEART BLOCK**
 Due to _____
 Due to _____

9. Birthplace **West Plains, Mo.**
(City, town, or county) (State or foreign country)
 10. Usual occupation **Retired**
 11. Industry or business **Farmer**

Other conditions **HAD STROKE 4 YEARS AGO. HAS BEEN BED FAST SINCE**
(Include pregnancy within 3 months of death)
 Major findings: **PHYSICIAN**
 Of operations _____
 Of autopsy **9:30**
 Underline the cause to which death should be charged statistically.

MOTHER FATHER
 12. Name **John L. McFarland**
 13. Birthplace **Georgia**
(City, town, or county) (State or foreign country)
 14. Maiden name **Mary McCall**
 15. Birthplace **Georgia**
(City, town, or county) (State or foreign country)

16. (a) Informant **Bertha Maude McFarland**
 (b) Address **Carterville, Mo.**
 17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **March 16 1947**
(Month) (Day) (Year)
 (c) Place: burial or cremation **Private Cemetery**

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 _____

18. (a) Signature of funeral director **Walt City Ltd Co.**
 (b) Address **Walt City, Mo.**
 19. (a) **MCH 15; 47** (b) **J. P. [Signature]**
(Date received local registrar) (Registrar's signature)

23. Signature **J. M. [Signature]** (M. D. or other) **Do.**
 Address **CARTERSVILLE MO** Date signed **3-13-47**

137

7-3-222

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 *Alveta M. Johnston*

Licensed Embalmer No. *4304*

P. O. Address *Webb City 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.