

U.S. DEPARTMENT OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **26460**  
**3402**  
Registrar's No. \_\_\_\_\_

FILED SEP 4 1948

Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
General Hospital No. 1 0  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In-hospital or institution 21 days  
(Specify whether years, months or days) 50 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48  
(c) City or town Kansas City 3  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4137 E. 6 St. 8  
(If rural, give location) 0  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3: (a) PRINT FULL NAME Adelaide McFarland

3. (b) If veteran, name war - 3. (c) Social Security No. 492-14-2320

4. Sex fe / 5. Color or race white 6. (a) Single, widowed, married, divorced, wid 2  
6. (b) Name of husband or wife Jefferson D. 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: Sept 9, 1877  
(Month) (Day) (Year)

8. AGE: Years 70 Months 11 Days 9 If less than one day hr. \_\_\_\_\_ min.

9. Birthplace Jewell Co. Kansas 1  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business at home

12. Name Robert Freeman 9  
13. Birthplace Unknown (City, town, or county) (State or foreign country)  
14. Maiden name Mary Dickinson  
15. Birthplace N.Y. 1 (City, town, or county) (State or foreign country)

16. (a) Informant Grace Breedlove

(b) Address 4137 E 6th

17. (a) Burial (b) Date thereof 8-20-1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Mt. Washington

18. (a) Signature of funeral director C.H. Blackman & Son, Inc.

(b) Address 2825 Independence Blvd.

19. (a) 8-20-48 (b) Geraldine Holmes  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 18  
year 1948 hour 8 minute 7 A. M.

21. I hereby certify that I attended the deceased from July 28, 1948, to Aug. 18, 1948;  
that I last saw her alive on Aug. 18, 1948;  
and that death occurred on the date and hour stated above.

Immediate cause of death Rheumatic heart disease

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

Other conditions 95-8  
(Include pregnancy within 3 months of death)

Major findings: See above  
Of operations \_\_\_\_\_  
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) (e) Means of injury \_\_\_\_\_  
23. Signature Wm W. Hart (M.D. or other) 8-10-48  
Address Med. Dir. Gen'l Hosp. Date signed \_\_\_\_\_

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

MOTHER, FATHER

*Mr. Andrews*

---

---

**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 *O. K. McFarland*

Licensed Embalmer No. *4397*

P. O. Address. *Kansas 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.**