No. 300
—10-47
5-17-39
I 3906

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED OCT 19 1948

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 33839

Registration District No. 316 — Primary Registration District No. 3059 — Registrar's No. 224

1. PLACE OF DEATH:

(a) County: St. Francois

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

(c) Name of hospital or institution: Bonne Terre Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 1/2 hours (Specify whether years, months or days)

In this community 70 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Madison

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

(d) Street No.: Buford Heights (If rural, give location)

(e) Citizen of foreign country? -No- (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Robert Marvin 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: Fannie McFarland

6. (c) Age of ~~husband or~~ wife if alive: 69 years

7. Birth date of deceased: Sept. (Month) 14, (Day) 1878 (Year)

8. AGE: Years 70 Months 0 Days 19 If less than one day ___ hr. ___ min.

9. Birthplace: Madison Co. (City, town, or county) Missouri (State or foreign country)

10. Usual occupation: Insurance broker

11. Industry or business:

FATHER

12. Name: Henry V. McFarland

13. Birthplace: Madison Co. (City, town, or county) Missouri (State or foreign country)

MOTHER

14. Maiden name: Elizabeth Payne

15. Birthplace: — (City, town, or county) Missouri (State or foreign country)

16. (a) Informant: Mrs. Fannie McFarland

(b) Address: Fredericktown, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10-6-48 (Month) (Day) (Year)

(c) Place: burial or ~~cremation~~: I.O.O.F. Cemetery

18. (a) Signature of funeral director: Webb-Adamson

(b) Address: Fredericktown, Mo.

19. (a) 10-12-48 (Date received by local registrar) (b) Esther Rudolph (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 3 year 1948 hour 4 minute 30 P.M.

21. I hereby certify that I attended the deceased from October 4, 1948 to October 4, 1948; that I last saw him alive on October 4, 1948; and that death occurred on the date and hour stated above.

Immediate cause of death: Coronary occulsion — Duration: 7 days

Due to:

Due to:

Other conditions: arteriosclerotic heart disease. ? (Include pregnancy within 3 months of death)

Major findings: hemorrhage from alimentary canal.

Of operations: (cause undetermined)

Of autopsy:

PHYSICIAN several hours

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? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: (M. D. or other) MD

Address: Bonne Terre, Mo. Date signed 10-3-48

(Licensed Embalmer's Statement on Reverse Side)

FILED

Health Officer No. 4

Number 1048-12

10-18-48

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 Edward G. Lehmann Jr.

Licensed Embalmer No. 4567

P. O. Address Frederickstown, Md.

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.

No. 300
1—10-47
5-17-39
I. 3906

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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

1949

1. PLACE OF DEATH:
(a) County: St. Francois.
(b) City or town: Bonne Terre (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Bonne Terre Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 1/2 hours (Specify whether years, months or days)
In this community 70 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Madison
(c) City or town: Fredericktown (If outside city or town limits, write "RURAL")
(d) Street No.: Buford Heights (If rural, give location)
(e) Citizen of foreign country? -No- (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME: Robert Marvin McFarland, Sr.
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: Fannie McFarland
6. (c) Age of ~~husband or~~ wife if alive: 69 years
7. Birth date of deceased: Sept. (Month) 14 (Day) 1878 (Year)
8. AGE: Years 70 Months 0 Days 19 If less than one day hr. _____ min.
9. Birthplace: Madison County (City, town, or county) Missouri (State or foreign country)
10. Usual occupation: Insurance broker
11. Industry or business _____
FATHER 12. Name: Henry V. McFarland
FATHER 13. Birthplace: Madison Co. (City, town, or county) Missouri (State or foreign country)
MOTHER 14. Maiden name: Elizabeth Payne
MOTHER 15. Birthplace: — (City, town, or county) Missouri (State or foreign country)
16. (a) Informant: Mrs. Fannie McFarland
(b) Address: Fredericktown, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10-6-48 (Month) (Day) (Year)
(c) Place: burial or ~~cremation~~: I.O.O.F. Cemetery
18. (a) Signature of funeral director: Webb-Adamson
(b) Address: Fredericktown, Missouri
19. (a) _____ (Date received local registrar) (b) _____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 3 year 1948 hour 4 minute 30 P.M.
21. I hereby certify that I attended the deceased from October 3, 1948, to October 3, 1948; that I last saw him alive on October 3, 1948; and that death occurred on the date and hour stated above.
Immediate cause of death: Coronary occlusion — Duration 7 days
Due to _____
Due to _____
Other conditions: arteriosclerotic heart disease. ? (Include pregnancy within 3 months of death)
Major findings: hemorrhage from alimentary canal.
Of operations: (cause undertermined)
Of autopsy _____
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? _____ (Specify type of place)
While at work? _____ (e) Means of injury _____
23. Signature: J. W. Taylor (M. D. or other) MD
Address: Bonne Terre, Missouri. Date signed 10-3-48

(Licensed Embalmer's Statement on Reverse Side)

S-33839

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 Valjean Adamson

Licensed Embalmer No. 4351

P. O. Address Fredericktown, M

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.