

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

24694

FILED AUG 11 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3065

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-57

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>General Hospital</u>		Length of stay in 1b <u>9 Yrs.</u>		d. STREET ADDRESS (If outside, give location) <u>831 W. 39th</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN EDWARD MC FARLAND</u>			4. DATE OF DEATH Month <u>June</u> Day <u>30</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 31, 1878</u>	9. AGE (In years last birthday) <u>78</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk, Kansas City</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Club</u>		11. BIRTHPLACE (City and state or country) <u>Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13a. FATHER'S NAME <u>Thomas W. McFarland</u>		13b. MOTHER'S MAIDEN NAME <u>Mary M. Richabaugh</u>	
13c. NAME OF HUSBAND OR WIFE <u>Mrs. Blanche McFarland</u>		14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <input type="checkbox"/> No, or unknown) <u>No</u>		15. SOCIAL SECURITY NO. <u>058-16-3019</u>	
16. INFORMANT <u>Mrs. Blanche McFarland,</u>		Address <u>831 W. 39th St. Kansas City, Mo.</u>		17. INTERVAL BETWEEN ONSET AND DEATH <u>8 1/2 25</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Skull + Fract Leg</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Foot Refused</u>	
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>One car struck Pedestrian</u>			
20c. TIME OF INJURY Hour <u>2:55</u> a.m. <u>pm</u> Month, Day, Year <u>6-30-57</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. CITY, TOWN, OR LOCATION <u>Kansas City</u>		20g. COUNTY <u>Jackson</u> STATE <u>MO</u>	
21. I attended the deceased from _____ to _____ and last saw him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Hugh A. Owens</u>		22b. ADDRESS <u>1034 Dakota Bldg</u>		22c. DATE SIGNED <u>7-1-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>July 2, 1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Moriah Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Jackson County, Missouri</u>		23e. STATE <u>Missouri</u>		24. FUNERAL DIRECTOR <u>Freeman Mortuary</u>	
24. ADDRESS <u>K. C. Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>7-2-57</u>		26. REGISTRAR'S SIGNATURE <u>Neve Minshall</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed Walter H. Carwin

Licensed Embalmer No. 4352

P. O. Address Kansas City

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.