

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-034478
STATE FILE NUMBER
8869

FILED SEP 22 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

8869

S. 300
1-57

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>04 BARNES HOSPITAL</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>2169 4024 DUNNICA</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGIA MAE McFARLAND</u>			4. DATE OF DEATH Month Day Year <u>SEPTEMBER 12, 1958</u>		
5. SEX <u>FEMALE</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>MAY 7, 1921</u>	9. AGE (In years last birthday) <u>37</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OFFICE WORKER</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>IRA SHANKS</u>		13b. MOTHER'S MAIDEN NAME <u>MARTHA DIXON</u>		14. NAME OF HUSBAND OR WIFE <u>AMOS McFARLAND</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT Address <u>AMOS McFARLAND 4024 DUNNICA</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>GASTROINTESTINAL HEMORRHAGE</u>					INTERVAL BETWEEN ONSET AND DEATH <u>36 HOURS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>ESOPHAGEAL VARICES</u>					<u>1 YEAR</u>
DUE TO (c) <u>TOXIC CIRRHOSIS OF LIVER</u> <u>581.0</u>					<u>3 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>IDIOPATHIC THROMBOCYTOPENIC PURPURA 12 YEARS</u>					19. WAS AUTOPSY PERFORMED? / YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input 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.)			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>APRIL 11, 1958</u> to <u>SEPT. 12, 1958</u> and last saw her alive on <u>SEPT. 12, 1958</u> Death occurred at <u>11:15 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>C. C. Vermillion, M.D.</u>			22b. ADDRESS <u>BARNES HOSPITAL</u>		22c. DATE SIGNED <u>9/13/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)
<u>REMOVAL</u>		<u>SEPT 15, 1958</u>	<u>MT. HOPE Cem.</u>		<u>ST. LOUIS Co. Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Thomas Rutis 2906 Gravois</u>			25. DATE RECD. BY LOCAL REG. <u>SEP 15 '58</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u> <u>BP</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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 *James C. Hill*

Licensed Embalmer No. *4347*
P. O. Address *2916 Evans*

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.