

MO. VS. AUG 24 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's **2 7471**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		a. STATE <b>MISSOURI</b>	b. COUNTY
Length of stay in 1b <b>45 years</b>		c. CITY OR TOWN <b>ST. LOUIS</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis City Hosp. # 1</b>		d. STREET ADDRESS (If outside, give location) <b>3515 Clark A ve.</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <b>RAYMOND</b>	Middle <b>MC FARLAND</b>	Last	4. DATE OF DEATH	Month <b>Aug.</b>	Day <b>8/59</b>	Year
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 26, 1896</b>	9. AGE (last birthday) <b>63</b>	IF UNDER 1 YEAR Months <b>4</b> Days <b>12</b>	IF UNDER 24 HR Hours <b>12</b> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Xenia, Ohio</b>	12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>
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13a. FATHER'S NAME <b>Gideon McFarland</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Gertrude McFarland</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes W.W.#1</b>	16. SOCIAL SECURITY NO. <b>198-03-0414</b>	17. INFORMANT <b>Gertrude McFarland 3515 Clark Ave.</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Uremia</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Chronic arteriolar nephrosclerosis</b>	
	DUE TO (c) <b>Generalized Atelectasis 442x</b>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Hypertensive Cardiovascular Disease, Pericarditis, Pleural Effusion</b>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)
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20c. TIME OF INJURY Hour _____ Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <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
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21. I attended the deceased from <b>8/3/59</b> to <b>8/8/59</b> and last saw him alive on <b>8/8/59</b> Death occurred at <b>4:00 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <b>Samuel W. Handy, M.D.</b>	22b. ADDRESS <b>1515 Lafayette Ave.</b>	22c. DATE SIGNED <b>8/10/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Aug. 12, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Crematory</b>	23d. LOCATION (City, town, or county) (State) <b>Jefferson Barracks, Mo.</b>
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24. FUNERAL DIRECTOR <b>J. H. RANDLE &amp; SON 3133 Bell Ave.</b>	25. DATE RECD. BY LOCAL REG. <b>AUG 11 '59</b>	26. REGISTRAR'S SIGNATURE <b>Harold Smith, M.D.</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 Ester K. Harris

Licensed Embalmer No. 4456

P. O. Address 4181 Was

\* 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.