

**TURK DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-039102**

**FILED VS. NOV 23 1959**

43

Primary Registration District No. 3007

Registrar's No. 531

STATE FILE NUMBER

MAILED

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Butler</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Missouri</b>				
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>Poplar Bluff</b>		Length of stay in 1b <b>6 wks</b>		c. CITY OR TOWN <b>Campbell</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>Doctors Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) <b>Highway 62</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>OTHAR</b> Middle <b>LEE</b> Last <b>McFARLAND</b>				<b>4. DATE OF DEATH</b> Month <b>NOVEMBER</b> Day <b>5</b> Year <b>1959</b>				
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Feb. 9, 1887</b>	<b>9. AGE</b> (last birthday) <b>72</b>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HR</b> Hours _____ Min. _____		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farming</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Dunklin county, Mo.</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>	
<b>13a. FATHER'S NAME</b> <b>John J. McFarland</b>			<b>13b. MOTHER'S MAIDEN NAME</b> <b>Patience Wethers</b>			<b>14. NAME OF HUSBAND OR WIFE</b> <b>Vada McFarland</b>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			<b>16. PATIENT SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> Address <b>Mrs. Vada McFarland, Campbell, Mo.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>Nephritis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 hrs</b> <b>?</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</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		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)				
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____								
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b>		<b>STATE</b>
<b>21. I attended the deceased from</b> <b>9/23/59</b> to <b>Nov. 5, 1959</b> and last saw <sup>him</sup> <del>her</del> alive on <b>Nov. 4, 1959</b> Death occurred at <b>3:15 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.								
<b>22a. SIGNATURE</b> <i>J. L. Shuerbe</i> (Degree or title)				<b>22b. ADDRESS</b> <b>Poplar Bluff, Mo</b>			<b>22c. DATE/SIGNED</b> <b>11/10/59</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE</b> <b>Nov. 7, 1959</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Woodlawn Cemetery</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>Campbell, Missouri</b>			
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Landess Funeral Home, Campbell, Mo.</b>				<b>25. DATE RECD. BY LOCAL REG.</b> <b>11/13/59</b>		<b>26. REGISTRAR'S SIGNATURE</b> <i>J. L. Shuerbe</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

900  
NOV 23 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by Charles Portain, Student Embalmer No. 591

working under my personal supervision.

Student Charles Portain  
Signature of Student Embalmer

Signed Christine M. Landes

Licensed Embalmer No. 422

P. O. Address Campbell

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.