

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-042133

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 316 Primary Registration District No. _____ Registrar's No. 444

FILED NOV 22 1961

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Doe Run</u> Length of stay in 1b <u>3 1/2 Yrs.</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION _____ Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Francois</u> c. CITY OR TOWN <u>Doe Run,</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> d. STREET ADDRESS _____ (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ALICE</u> Middle <u>A.</u> Last <u>McFARLAND</u>			4. DATE OF DEATH Month <u>November</u> Day <u>14</u> Year <u>1961</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>4/1/1877</u>	9. AGE (last birthday) <u>84</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>13</u>	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <u>Palroy, Ohio</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Austin Kirkendall</u>		13b. MOTHER'S MAIDEN NAME <u>Betty Sleeth</u>		14. NAME OF HUSBAND OR WIFE <u>John 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>none</u>	17. INFORMANT Address <u>John McFarland Doe Run, Mo.</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>Cerebral Epilepsy</u> DUE TO (b) <u>arteriosclerosis & senility</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					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	
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.)				
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. p.m.						
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.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE				
21. I attended the deceased from <u>Oct 3, 1961</u> to <u>Nov 6, 1961</u> and last saw him alive on <u>Oct 31, 1961</u> Death occurred at <u>10:25</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or Title) <u>[Signature]</u>			22b. ADDRESS <u>[Address]</u>		22c. DATE SIGNED <u>11/17/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11/17/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pencheson Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Doe Run, Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Murphy L. Sparks Flat River, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>Nov. 17, 1961</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

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 Murphy Sparks

Licensed Embalmer No. 4236

P. O. Address St. Louis

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.