MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

File No. 326
Registered No. 24103

1. PLACE OF DEATH
County: Greene
Registration District No.: 318
Township:
Primary Registration District No.: 2001
City: Springfield (No. St. Ward): St. John's Hospital

2. FULL NAME: Charles Keyes McCarthy
(a) Residence, No. Polk County St., Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: Wh.
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*): Single

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Dec 18, 1932

7. AGE: Years 1 Months 5 Days 21 If LESS than 1 day, ... hrs. or ... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Polk Co.

FATHER
13. NAME: J. R. McCarthy
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Polk Co.

MOTHER
15. MAIDEN NAME: Emma Keyes
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Chippewa Falls Wisconsin

17. INFORMANT (ADDRESS): J. R. McCarthy

18. BURIAL, CREMATION, OR REMOVAL
PLACE: Bolivar DATE: 7-16, 1934

19. UNDERTAKER (ADDRESS): White Undertaking Co. Bolivar Mo.

20. FILED July 16, 1934 [signature]

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 7-12-1934

22. I HEREBY CERTIFY, That I attended deceased from 7-11-1934, to 7-12, 1934
I last saw him alive on 7-11-1934. Death is said to have occurred on the date stated above, at 2 A.M.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Flex Colitis	7-3-1934
Ileus	
Toxic	

Other contributory causes of importance:

Toxic Encephalitis	7-11-34

Name of operation: Date of:
What test confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) [signature], M. D.
(Address) Springfield, Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

AUG 8 1934

#2 Green Springfield

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
WASHINGTON

E. T. McGaugh, M. D.,
Special Agent,
Jefferson City, Mo.

326

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Charles Lejei McCarthy
Who died at _____ on July 12, 1934
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years 1 Months 3 Days 2
Sex M Color or race W Single, ~~married, widowed or divorced~~: _____

Date of birth _____ Age: Years _____ Months _____ Days _____

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____

(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

Date deceased last worked at this occupation: Month _____ Year _____
Birthplace (State or country) _____
Birthplace of father (State or country) _____
Birthplace of mother (State or country) _____
Principal cause of death: Toxic Encephalitis 19 b
Other contributory causes of importance _____
Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____
If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19 _____
Where did injury occur? _____
(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____
Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
Name of physician _____
Address of physician _____
Signature of Registrar [illegible] Date filed 7/12/1934

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. 318

Primary Reg. Dist. No. 2001

Very truly yours,

E. T. McGaugh M. D.
Special Agent.

24103