

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.

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

Do not use this space.

546 JAN 14 1935

1. PLACE OF DEATH

County *Deukhonon*

Registration District No. **85**

Township

Primary Registration District No. **1001**

City *St. Joseph* (No. *1001*)

File No. **42090**

Registered No. **1428**

2. FULL NAME

(a) Residence No. *McCall Mo* St. *St. Joseph* Ward.

Length of residence in city or town where death occurred — yrs. — mos. **21** ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <i>Male</i>	4. COLOR OR RACE <i>White</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>widowed</i>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <input checked="" type="checkbox"/>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>June 7 - 1860</i>		
7. AGE	YEARS <i>74</i>	MONTHS <i>6</i>
	DAYS <i>20</i>	IF LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>Farming</i>	11. Total time (years) spent in this occupation
	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)	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Missouri</i>		
FATHER	13. NAME <i>James T. Egan</i>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>St. Louis Missouri</i>	
MOTHER	15. MAIDEN NAME <i>Wm. Lock</i>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>St. Louis Missouri</i>	
17. INFORMANT (ADDRESS) <i>Wm. L. Egan, McCall Mo</i>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <i>McCall Mo</i> DATE <i>12-29</i> 19 <i>34</i>		
19. UNDERTAKER (ADDRESS) <i>J. H. Stringly, St. Joseph Mo</i>		
20. FILED <i>12-28</i> 19 <i>34</i> <i>John K. Bender</i> Registrar.		

V MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Dec 27, 1934*

22. I HEREBY CERTIFY, That I attended deceased from *Dec 6, 1934* to *Dec 27, 1934*

I last saw him alive on *Dec 27, 1934* Death is said to have occurred on the date stated above, at *4:20 p.m.*

The principal cause of death and related causes of importance were as follows:
Chronic Myocarditis
Senility *Primaert*

Date of onset *93*

Other contributory causes of importance: *93*

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? *Yes*
If so, specify _____
(Signed) *J. B. Burch*, M. D.
(Address) *State Hosp #2*

