

MAY 11 1939

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

Do not use this space.

702

85

14262

1. PLACE OF DEATH

County Buchanan
Township Washington
City St. Joseph

Registration District No. _____
Primary Registration District No. 1001
State Hospital # 2

File No. _____
Registered No. 385
St. _____ Ward _____

2. FULL NAME

John Walter McLaughlin

(a) Residence, No. State Hospital # 2 St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED wid
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF not known

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Unknown 1873

7. AGE YEARS 66 MONTHS Unknown DAYS Unknown If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Chronic invalid

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) Unknown Ill.

13. NAME Unknown McLaughlin

14. BIRTHPLACE (CITY OR TOWN), (STATE OR COUNTRY) Unknown Ill.

15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN), (STATE OR COUNTRY) Unknown Ill.

17. INFORMANT (ADDRESS) Raymond McLaughlin @ 216

18. BURIAL, CREMATION, OR REMOVAL PLACE State Hospital DATE April 12 1939

19. UNDERTAKER (ADDRESS) E. R. Sidenfaden Funeral Home
602 S. South 10th Street

20. FILED 4-11-39 H. H. McLaughlin
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr. 9 1939

22. I HEREBY CERTIFY, that I attended deceased from Mar. 8, 1939 to Apr. 9, 1939
I last saw him alive on Apr. 9, 1939. Death is said to have occurred on the date stated above, at 2:40 a.m.

The principal cause of death and related causes of importance were as follows

Arteriosclerosis

Date of onset ?

Other contributory causes of importance:

Pneumonia

4/6/39

Name of operation none Date of _____
What test confirmed diagnosis? clinical 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? no
If so, specify _____

(Signed) T. J. O'Sell, M. D.
(Address) St. Joseph

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

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.

STATEMENT BY LICENSED EMBALMER

I, _____, Licensed Embalmer No. _____
do hereby certify that the body received on the reverse side of this

Certificate was embalmed by _____

or by _____, Registered Apprentice No. _____

Not Embalmed

Theron Smith

Licensed Embalmer No. *3928*

NOTE: This certificate is valid only if signed by the licensed embalmer in his own handwriting.
(Public Health Law, § 2105) constitutes grounds for revocation of license.