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.

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

NOV 20 1939

35574
Do not use this space.

1. PLACE OF DEATH
(a) County BUCHANAN / Registration District No. 85
(b) Township / Primary Registration District No. 1001 Registered No. 1095
(c) or City ST. JOSEPH / (d) Street No. ST. JOSEPH HOSPITAL St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. / ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 545 Patrick Harris Scanlan
(a) Residence, No. 3815 Mitchell St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Newborn
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 10-23-39.
7. AGE YEARS 0 MONTHS 0 DAYS 0 If LESS than 1 day, 11 hrs. or 2 min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none
9. Industry or business in which work was done, as 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) St Joseph Mo.

FATHER
13. NAME Paul W. Scanlan
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St Joseph Mo.

MOTHER
15. MAIDEN NAME Gladys M. Harris
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St Joseph Mo.

17. INFORMANT (ADDRESS) Paul W. Scanlan 3815 Mitchell Ave. St. Joseph, Mo.
18. BURIAL, CREMATION, OR REMOVAL Mt. Olivet Cem't.
PLACE St. Joseph, Mo. DATE Oct. 24, 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) H. O. Sidenfaden & Son 1802 Union Str. St. Joseph, Mo.
20. FILED Oct. 24, 1939 H. J. Nestlebach Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-24, 1939
22. I HEREBY CERTIFY, That I attended deceased from Oct 23, 1939, to Oct 24, 1939
I last saw him alive on Oct 23, 1939. Death is said to have occurred on the date stated above, at 9:49 a m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Atelectasis	10/23/39
Atelectasis	

Other contributory causes of importance: 161 a

Name of operation None Date of
What test confirmed diagnosis? Clinic 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) Frank H. Hardegger, M. D.
(Address) Kenpatrick Bldg.

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....

working under my personal supervision. not embalmed

Signed. Elbert R. Harrington

Licensed Embalmer No. 3258.

P. O. Address St. Joseph, Mo.

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 this body is not embalmed, above space should be left blank.