

Registration District No. 582

Primary Registration District No. 4344

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Monroe
(b) City or town Paris
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ✓
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Monroe
(c) City or town Paris
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years

3. (a) PRINT FULL NAME MATTIE RADIGAN 825

3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓

4. Sex female 5. Color or race Negro 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Thos. Radigan 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Th. H.
(Month) (Day) (Year)

8. AGE: Years about 59 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Paris Mo. (L)
(City, town, or county) (State or foreign country)

10. Usual occupation at home

11. Industry or business _____

MOTHER FATHER
12. Name Harvey Gonzers
18. Birthplace Paris Mo. (L)
(City, town, or county) (State or foreign country)
14. Maiden name Jane Pogue
15. Birthplace Monroe Co., Mo. (L)
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature (Hos X) Mary Jane Hipp

(b) Address Paris, Mo

17. (a) burial (b) Date thereof Mar. 3, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Walnut Street

18. (a) Signature of funeral director Speldorfsky
(b) Address Paris, Mo

19. (a) 2-27-40 (b) J. A. Barrett, M.D.
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 27
year 1940 hour 3 minute 0 P. M.

21. I hereby certify that I attended the deceased from 2-27-40
_____, 19____, to 2-27-40, 19____;
that I last saw her alive on 2-27-40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death cerebral thrombosis Duration NA

Due to arteriosclerosis

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy none

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature Fellis & Christman M.D. or other _____
Address Paris, Mo. Date signed 2/27/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rev. 5-17-39 50M-5-17-39 I X1511

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.

RECEIVED

District Health Officer No. 10

District File Number 3-40-650

Date Filed MAR 13 1940

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.

Signed E. H. Agnew

Licensed Embalmer No. 4000

P. O. Address Paris, Missouri

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.