

Registration District No. 129 Primary Registration District No. 5180 Registrar's No. _____

1. PLACE OF DEATH:

(a) County Cape Girardeau
 (b) City or town Rural (Shannon Twp)
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Near Fruitland, Mo.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2
 (Specify whether
 In this community all of life
 years, months or days)

3. (a) PRINT FULL NAME JOHN McLAUGHLIN

3. (b) If veteran, name war _____ 3. (c) Social Security No. none

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced divorced
 6. (b) Name of husband or wife Rhona Rooney 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased 7 13 1878
 (Month) (Day) (Year)

8. AGE: Years 61 Months 8 Days 14 If less than one day hr. _____ min. _____

9. Birthplace _____ (City, town, or county) (State or foreign country) ✓ 1

10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER
 { 12. Name J. S. McLaughlin
 13. Birthplace Nelsum, Mo. Mo. / Mo. / (City, town, or county) (State or foreign country)
 14. Maiden name unknown
 15. Birthplace _____ (City, town, or county) (State or foreign country) 9

16. (a) Informant's own signature Mrs. Daisy Gerold

(b) Address Rt. 1, Near Carlsbad, Ind

17. (a) Burial (b) Date thereof 6-1-1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Apple Creek, Conn

18. (a) Signature of funeral director R. G. Miller

(b) Address Carlsbad, Mo

19. (a) 3-30-1940 (b) D. G. Stubbs
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Cape Girardeau
 (c) City or town Rural (Shannon Twp)
 (If outside city or town limits, write "RURAL")
 (d) Street No. 0 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 28
 year 1940 hour 5 minute 30 P.M.

21. I hereby certify that I attended the deceased from 12 M. Mar 28
2 8th - 1940 19. to 6:30 P.M. Mar 28 19. 40
 that I last saw him alive on Mar 28 19. 40
 and that death occurred on the date and hour stated above.

Immediate cause of death lobar pneumonia Duration 3 or 4 days

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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 _____

28. Signature D. G. Stubbs M.D. (M. D. or other)

Address Jackson Mo Date signed 3-30-40

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

Rev. 5-1-39 I 19151

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should 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 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.....

Lynna Steele

Licensed Embalmer No.....

2476

P. O. Address.....

Jackson 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10548

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 129

Primary Registration District No. 5180

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town Shannon
(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)

3. (a) PRINT FULL NAME

John McLaughlin

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Div
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years
7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 61 Months 8 Days 14 If less than one day _____ min.

9. Birthplace Murphysboro, Ill. (City, town, or county) (State or foreign country)

MOTHER FATHER

10. Usual occupation _____
11. Industry or business _____
12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (Place: burial or cremation)

18. (a) Signature of funeral director _____ (b) Address _____
19. (a) 5-2-40 (Date received local registrar) (b) F. J. Schorn (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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

20. DATE OF DEATH Month Mar day 28 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____ that I last saw him alive on _____ 19 _____ and that death occurred on the date and hour stated above.

Immediate cause of death _____
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____ Of autopsy _____

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 D. G. Subert (M. D. or other) Address Jackson mo Date signed _____

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

SUPPLEMENTAL COPY

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

S-10548 1940

RECORDED - 10548 - 1940