

Registration District No. 735

Primary Registration District No. 3034

Registrar's No. 51

1. PLACE OF DEATH:

(a) County Randolph

(b) City or town Moberly
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
520 No. 7th St.
(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 _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph

(c) City or town Moberly
(If outside city or town limits, write "RURAL")

(d) Street No. 520 No. 7th St.
(If rural, give location) 0

(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Andrew P. McKeough 2nd

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

4. Sex male 5. Color or race White 6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased March 27th 1884
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

55 11 14 _____ hr. _____ min.

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

10. Usual occupation Retired

11. Industry or business _____

MOTHER FATHER

12. Name Patrick McKeough

13. Birthplace Ireland
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Kennedy

15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs Kate Cherrington

(b) Address Moberly, Mo

17. (a) burial (b) Date thereof March 13th 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Moberly, Mo

18. (a) Signature of funeral director Mahan and Son

(b) Address Moberly, Mo

19. (a) MAR 13-1940 (b) Leah Williams
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 11th
year 1940 hour 3 minute 50 P. M.

21. I hereby certify that I attended the deceased from Mar 30, 1940, to Mar 11, 1940
that I last saw him alive on Mar 11, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia Duration 3 days

Due to _____

Due to _____

Other conditions Arthritis Deformans
(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? 0

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

23. Signature Chas W. Harris (M. D. or other) DC
Address 517 7th St Date signed 3-13-40

WRITE LEGIBLY—USE UNFADING BLACK INK—MAKE 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.

RECEIVED

Director Health Officer No. 10

Date: Number 4-40-899

APR 16 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 *Frank D. DeWitt*

Licensed Embalmer No. *3021*

P. O. Address *Moberly 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 121387

Registration District No. 735

Primary Registration District No. 3034

Registrar's No. 57

1. PLACE OF DEATH:

(a) County Randolph

(b) City or town Provenza
(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
years, months or days)

In this community.....

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.

3. (a) PRINT FULL NAME Andrew P. McKeough

3. (b) If veteran, name war.....

3. (c) Social Security No.....

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Mar day 11
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.

4. Sex m 5. Color or race w

6. (a) Single, widowed, married, divorced single

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)

Immediate cause of death.....

Due to.....

Due to.....

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

Major findings:
Of operations.....

Of autopsy.....

8. AGE: Years 53 Months 11 Days 14 If less than one day min.

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

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)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) Mar 13-40 (Date received local registrar)

(b) Leah Williams (Registrar's signature)

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.....

23. Signature Chas W. Harris (M. D. or other)

Address Provenza State signed.....

SUPPLEMENTARY

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

PAULENA MOORE

1940
S-12138