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State File No. _____

Registration District No. 625

Primary Registration District No. 3031

Registrar's No. 97

1. PLACE OF DEATH:

(a) County Wodaway

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

(c) Name of hospital or institution: St. Francis Hospital
(If not in hospital or institution, write street number & location)

(d) Length of stay: In hospital or institution 3 hours
(Specify whether)

In this community 212
years, months or days

3. (a) PRINT FULL NAME Hugh Luther McVaigh

3. (b) If veteran, 487-05-8034 (c) Social Security No. _____

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

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

7. Birth date of deceased: 12-16-1916
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<u>23</u>	<u>23</u>	<u>7</u>	<u>7</u>	_____ hr. _____ min.

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

10. Usual occupation Mechanic for Burroughs Addy Machinery Co.

11. Industry or business _____

MOTHER FATHER { 12. Name Hugh McVaigh

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

14. Maiden name Ruth Robertson

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

16. (a) Informant Harry F. Riarden

(b) Address 212 W. Torrance, Maryville, Mo.

17. (a) Removal (b) Date thereof July 23, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation Highland Park

18. (a) Signature of funeral director Wm. Campbell Funeral Home

(b) Address Maryville, Mo.

19. (a) 7-23-1940 (b) Wm. E. Clardy
(Date of local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Beckham

(c) City or town St. Joseph, Mo.
(If outside city or town limit, write "RURAL")

(d) Street No. 1708 North 9th St.
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 23
year 1940 hour 12 minute 35 P.M.

21. I hereby certify that I attended the deceased on July 23, 1940, 19____; that I last saw him alive on July 23, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Crushing injuries thru base of skull Duration 3 hours

Due to automobile wreck; car skidded on gravel after passing another car, and overturned.

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) accident

(b) Date of occurrence July 23, 1940

(c) Where did injury occur near Fairfax, Atchison Co., Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? 556, public road
(Specify type of place) (e) Means of injury auto wreck

While at work? _____

23. Signature H. C. Bannan (M. D. or other) MD
Address St. Joseph, Mo. Date signed 7/23/40

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

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.....

William Campbell..... Registered Apprentice No.....
working under my personal supervision.

Signed..... *William Campbell*.....

Licensed Embalmer No. *2620*

P. O. Address *Maryville 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. **20876**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **628**

Primary Registration District No. **3031**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Madawaska**
(b) City or town **Madawaska**
(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 _____ (Specify whether _____)
years, months or days _____

3. (a) PRINT FULL NAME

Hugh Luther Mc Leigh

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **M**

5. Color or race **W**

6. (a) Single, widowed, married, divorced **M**

6. (b) Name of husband or wife _____

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

7. Birth date of deceased **12**
(Month) (Day) (Year)

16-1916
(Day) (Year)

8. AGE:

Years **23** Months **7** Days **7**

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 _____

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **7-23-40**
(Date received local registrar)

(b) **Mamie E Clardy**
(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.

19. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **23**
year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ 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 _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTAL COPY

MOTHER FATHER

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

