

13-40
339
23159

Registration District No. 26 Primary Registration District No. 3002 Registrar's No. 164

1. PLACE OF DEATH:
(a) County Andrain
(b) City or town Mexico
(c) Name of hospital or institution: home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community Mexico, Mo. 30 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME: JAMES ROBERT FEGAN
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 widowed
6. (b) Name of husband or wife Ella Fegan 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: April 7 - 1860
(Month) (Day) (Year)

8. AGE: Years 80 Months 8 Days 12 If less than one day hr. _____ min. _____

9. Birthplace: Mason Co. Ky.
(City, town, or county) (State or foreign country)

10. Usual occupation Drayman
11. Industry or business Hauling

12. Name James E. Fegan
13. Birthplace Ky.
(City, town, or county) (State or foreign country)
14. Maiden name Mary E. Stevenson
15. Birthplace Ky.
(City, town, or county) (State or foreign country)

16. (a) Informant JR Fegan
(b) Address Ladonia Mo.

17. (a) burial (b) Date thereof Dec 20 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Ladonia Mo.

18. (a) Signature of funeral director H. S. Trainger
(b) Address Ladonia Mo.

19. (a) Dec - 19-1940 (b) Blanche Kelly
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Andrain
(c) City or town 504 S. Calhoun
(If outside city or town limits write "RURAL")
(d) Street No. 504 S Calhoun
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month DEC. day 19
year 1940 hour 3 minute 30 A.M.
21. I hereby certify that I attended the deceased from DEC
1939 19 to DEC. 19 1940
that I last saw him alive on DEC. 16 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia
Due to Chronic Hypertension
Due to Arterio Sclerosis

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?

23. Signature: H. S. Trainger (M. D. or other) 3
Address Mexico Mo. Date signed 12/19/40

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

MOTHER FATHER

97

RECEIVED

District Health Officer No. 10

District File Number 1-41-141

JAN 16 1941

Date Filed

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.....

H. G. Granger

Registered Apprentice No.....

working under my personal supervision.

Signed.....

H. G. Granger

Licensed Embalmer No. 1297

P. O. Address

Laddonia, T.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 41715
Registrar's No. _____

Registration District No. 216

Primary Registration District No. 3002

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

1. PLACE OF DEATH:

(a) County Andrain
(b) City or town Mexico
(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

James Robert Legaw

(b) If veteran name war _____

3. (c) Social Security No. _____

4. Sex M

5. Color or race W

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

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 80 Months 8 Days 17

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) _____ (b) _____

(Date received local registrar) (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

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Dec day 19
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 Uremia
Chronic Nephritis
Due to Chr. Hypertension
arterio sclerosis

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 J. D. Ashburn (M. D. or other) _____
Address MEXICO MO Date signed 2-10-41

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

S-41715-1940