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Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MAILED MAR 20 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

7729

State File No. _____

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Madawsony
(b) City or town Conception Jct Mo
(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 11 (Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Madawsony
(c) City or town Conception Jct Mo
(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 MARGARET EGAN

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

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive 82 years

7. Birth date of deceased 3 (Month) 1860 (Day) (Year)

8. AGE: Years 80 Months 11 Days 26 If less than one day _____ hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Thomas Jay

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

14. Maiden name Margaret Harmon

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

16. (a) Informant Katharine Debs (b) Address Stauffery Mo.

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation Conception Mo

18. (a) Signature of funeral director Wm J. Quinn (b) Address Conception Jct Mo

19. (a) 2-10 (Date received local registrar) (b) Carol Egan (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 9 year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from July 2, 1932, to 2-9, 1941; that I last saw her alive on 2-1, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Myocarditis
Endocarditis

Due to Arteriosclerosis

Due to Hypertension

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

23. Signature Dr. Boyles (M. D. or other) _____ Address Conception Jct Date signed 2-19-41

Duration

_____ yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

74
0
0

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 _____
_____, Registered Apprentice No. _____
working under my personal supervision.

Signed _____

Licensed Embalmer No. 1675

P. O. Address Mayville Md

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. 7729

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 620

Primary Registration District No.

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Madaway
(b) City or town Jefferson T.P.
(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 Margaret Egan

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

4. Sex F 5. Color or race white 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife Maurice Egan 6. (c) Age of husband, or wife, if alive 82 year

7. Birth date of deceased Mar. 3 1860
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>79</u>	<u>11</u>	<u>26</u>	hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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) Anna Egan
(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.

20. DATE OF DEATH: Month 2 day 9
year 1941 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 _____
The certdate is correct
Due to this person would be
Due to 80 yrs 11 months and 6 days
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

Duration
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 J. M. Boyles (M. D. or other) _____
Address Conception Det. Bawland

SUPPLEMENTAL

