

2  
41  
39  
26330

FILLED NOV 17 1944

Registration District No. ....

Primary Registration District No. ....

Registrar's No. **304**

1. PLACE OF DEATH

(a) County **Adair**  
(b) City or town **Kirksvill**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **Community Nursing Home**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In **home** or institution **4 months**  
(Specify whether years, months or days)  
In this community **4 months**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Sullivan**  
(c) City or town **Milan - Rural**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **Rt # 2**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country **/**

3. (a) PRINT FULL NAME **John Edw. McGinty**

3. (b) If veteran, name war **no**  
3. (c) Social Security No. **None**

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

6. (b) Name of husband or wife  
6. (c) Age of husband or wife if alive **1869** years

7. Birth date of deceased **April 14** (Month) **1869** (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>72</b>	<b>6</b>	<b>19</b>	hr. min.

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

10. Usual occupation **Farmer**

11. Industry or business

12. Name **Peter McGinty**  
13. Birthplace **4 Ireland**  
(City, town, or county) (State or foreign country)

14. Maiden name **Catherine Murphy**  
15. Birthplace **4 Ireland**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Grace Maxwell**

(b) Address **Milan, Mo.**

17. (a) **Burial** (b) Date thereof **Nov 6 1944**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Marys Cem**

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

(b) Address **Milan, Mo.**

19. (a) **Nov 5/41** (b) **Spencer E. Freeman**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **3**  
year **1941** hour **11** minute **15** P.M.

21. I hereby certify that I attended the deceased from **July 10** 1941 to **Nov 3** 1941;  
that I last saw him alive on **Nov 3** 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral hemorrhage** Duration **72 hrs.**

Due to **High blood pressure**

Due to **arteriosclerosis**

Other conditions **Two previous strokes**  
(Include pregnancy within 3 months of death)  
**1st Aug 1940, 2nd June 1941**

Major findings **835**  
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

23. Signature **M. T. Antevush** (M.D. or other) **Do**  
Address **Kirksvill, Mo.** Date signed **Nov 3 1944**

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

MOTHER FATHER

RECEIVED

District Health Officer No. 10

District File Number 11-41-1999

Date Filed NOV 13 1941

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.....

Frank D. Schwen

Registered Apprentice No.....

working under my personal supervision.

Signed

Frank D. Schwen

Licensed Embalmer No. 2016

P. O. Address Milan, 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.