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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 3 1945

Registration District No. 745

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 7733

Primary Registration District No. 6020-a

Registrar's No. 3

94
2
1

1. PLACE OF DEATH:
(a) County St Francois
(b) City or town Bonne Terre
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Bonne Terre Hospital
(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: 94
(a) State Missouri (b) County St Francois
(c) City or town Flat River 5
(If outside city or town limits write "RURAL") 2
(d) Street No. 225 Crane
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME ROBERT J McGAHAN
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 Married
6. (b) Name of husband or wife Dallie McGahan
6. (c) Age of husband or wife if alive 59 years
7. Birth date of deceased April (Month) 12 (Day) 1879 (Year)
8. AGE: Years 62 Months 9 Days 26 If less than one day ____ hr. ____ min.
9. Birthplace Bonne Terre (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Miner
11. Industry or business ____
MOTHER FATHER
12. Name George McGahan
13. Birthplace Unknown (City, town, or country) (State or foreign country)
14. Maiden name Mary Ann Allen
15. Birthplace Unknown (City, town, or country) (State or foreign country)
16. (a) Informant John G. McGahan
(b) Address R.0 49 Potosi St Louis Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 16 1942 (Month) (Day) (Year)
(c) Place: burial or cremation Park View
18. (a) Signature of funeral director Diemer Funeral Home
(b) Address Flat River, Mo
19. (a) Jan 22 1942 (Date received local registrar)? (b) N. W. Hawkins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 14 year 1942 hour 5 minute 40 P. M.
21. I hereby certify that I attended the deceased from Jan 14, 19 42 to Jan 14, 1942 that I last saw him alive on Jan 14, 1942 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hemorrhage from Nose & gums - Intestinal tract	24 hrs
Due to: Hypertensive Cardio Vascular Disease	2 to 3 yr
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings: Of operations None was done
Of autopsy None was made

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

22. If death was due to external causes, fill in the following: No
(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 N. W. Hawkins (M. D. or other)
Address Farmington, Mo Date signed Jan 15 1942

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

(Licensed Embalmer's Statement on Reverse Side)

MAR 4 1942
RECEIVED

District Health Officer No. 4
District File Number 242-204
Date Filed 2-11-42

OCT 8 1954

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~~ and Leonard John Vargo, Registered Apprentice No. 311, working under my personal supervision.

Signed G. F. Claywell

Licensed Embalmer No. 3706

P. O. Address Bound Brook, N.J.

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.

. S. No. 2B
0M—8-21-41
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 7733

Registration District No. 775 Primary Registration District No. 6620-a Registrar's No.

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

1. PLACE OF DEATH:
(a) County St Francois
(b) City or town Bonne Terre
(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) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Robert J. McGahan
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 Apr (Month) 12 (Day) 18 (Year)
8. AGE: Years 62 Months 9 Days If less than one day 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day 14 year 1942 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.

	Duration
Immediate cause of death	
(a) Hemorrhage of nose	
Due to Cause undetermined	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations 103	
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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature N. W. Hawkins (M. D. or other)
Address Farmington, Mo. Date signed 4-9-42

SUPPLEMENTARY

S-7733