S. No. 2
—1-4-41
17-39
X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 14 1942

Registration District No. 44

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 4056

State File No. 17585

Registrar's No. 19

1. PLACE OF DEATH:
(a) County: Caldwell
(b) City or town: Breckenridge Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(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: 83 - 5 - 27

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo. (b) County: CALDWELL
(c) City or town: BRECKENRIDGE 13
(If outside city or town limits, write "RURAL") 0
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: PATRICK SCANLON
3. (b) If veteran, name war: no
3. (c) Social Security No.: no
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widower
6. (b) Name of husband or wife: Addie Wagoner
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: NOV. (Month) 19 (Day) 1858 (Year)

8. AGE: Years 83 | Months 5 | Days 27 | If less than one day ____ hr. ____ min.

9. Birthplace: BRECKENRIDGE (City, town, or county) MO. 0 (State or foreign country)
10. Usual occupation: Retired Farmer
11. Industry or business:
FATHER 12. Name: JOHN SCANLON
FATHER 13. Birthplace: BALLAGLASS (City, town, or county) IRELAND (State or foreign country)
MOTHER 14. Maiden name: ANNA MC NICHOLS
MOTHER 15. Birthplace: BALLAGLASS (City, town, or county) IRELAND (State or foreign country)
16. (a) Informant: W A Scanlon
(b) Address: BROOKFIELD MO.
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: May 8 1942 (Month) (Day) (Year)
(c) Place: burial or cremation: ROSE HILL
18. (a) Signature of funeral director: T F McBeth
(b) Address: Breckenridge mo.
19. (a) May 8 - 1942 (Date received local registrar) (b) E L Thompson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: May day: 6th
year: 1942 hour: 6:00 minute: P. M.
21. I hereby certify that I attended the deceased from: Mch 5th 1942 to: May 6 1942
that I last saw him alive on: May 6th 1942
and that death occurred on the date and hour stated above.

Immediate cause of death: Myocardial Insufficiency — Duration: 2 mont
Due to: Dont Know
Due to: Dont Know
Other conditions: uraemia
(Include pregnancy within 3 months of death)
Major findings:
Of operations: None
Of autopsy: None

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? (Specify type of place)
While at work? (e) Means of injury: 0
23. Signature: W. L. Cleaffin (M. D. or other) M D
Address: Breckenridge Mo Date signed: May 12 1942

1151

(Licensed Embalmer's Statement on Reverse Side)

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 T.F. McPeek, Registered Apprentice No. ....., working under my personal supervision.

Signed T.F. McPeek

Licensed Embalmer No. 1570

P. O. Address Breckenridge 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, fact should be so stated above.

. S. No. 2B
)M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 17585

Registration District No. 94 Primary Registration District No. 450 Registrar's No.

1. PLACE OF DEATH:
(a) County Caldwell
(b) City or town Breckenridge
(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 Patrick Scanlon
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 W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Nov (Month) 19 (Day) 1858 (Year)
8. AGE: Years 83 Months 5 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 May Day 6 year 1942 hour minute M.
21. I hereby certify that I attended the deceased from 19 , 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 Uremia	
Due to chronic Interstitial	
Due to Nephritis	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 1210
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature W. L. Chaffen M.D. (M. D. or other)
Address Breckenridge Mo Date signed 7-10-42

SUPPLEMENTARY