DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 10 1942

29484

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 29965

Registration District No. 47 | Primary Registration District No. 3164 | Registrar's No. 314

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

1. PLACE OF DEATH:

(a) County: Calloway

(b) City or town: Rural – St Aubert
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Calloway Co. Infirmary
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: about 2 years (Specify whether years, months or days)

In this community:

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Calloway

(c) City or town: Rural St Aubert
(If outside city or town limits, write "RURAL")

(d) Street No.: R#6 Fulton
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country:

3. (a) PRINT FULL NAME: JAMES MAHONY

3. (b) If veteran, name war: Dk

3. (c) Social Security No.: Dk

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, divorced: ✗ ✗ ✗ 0

6. (b) Name of husband or wife:

6. (c) Age of husband or wife if alive: years

7. Birth date of deceased: 3 (Month) – 26 (Day) 1866 (Year)

8. AGE: Years 82 | Months 6 | Days 12 | If less than one day: hr. min.

9. Birthplace: Don't Know (City, town, or county) 9 (State or foreign country)

10. Usual occupation: Inmate of Infirmary

11. Industry or business:

MOTHER FATHER

12. Name: Don't Know

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

MOTHER

14. Maiden name: Don't Know

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

16. (a) Informant: Carl S Houchins

(b) Address: R#6 Fulton

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9-29-42 (Month) (Day) (Year)

(c) Place: burial or cremation: County Infirmary

18. (a) Signature of funeral director: C. L. Houchins

(b) Address: R#6 Fulton

19. (a) 9-29-42 (Date received local registrar) (b) Joyce Morsmitchoff (Registrar's signature)

1147 (Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 27 year 1942 hour 2 minute 30 P M.

21. I hereby certify that I attended the deceased from July 16, 1942 to Sept 27, 1942 that I last saw him alive on Sept 26, 1942 and that death occurred on the date and hour stated above.

Immediate cause of death: Pneumonia – Hypostatic Congestion — Duration: Several weeks

Due to: To Spinning Bed with Fractured Hip

Due to:

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): 014

(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 O Payne (M.D. or other)

Address: R#6 Fulton Date signed: 9-28-42

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.....

P. O. Address.....

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.

S. No. 2B
1—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. 29968

Registration District No. 47 Primary Registration District No. 5164 Registrar's No. 314

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

1. PLACE OF DEATH:
(a) County: Callaway
(b) City or town: (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: James Mahony
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: S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: Mar (Month) 27 (Day) 1848 (Year)
8. AGE: Years Months 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 Sept. Day 4 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.

Immediate cause of death: Pulmonary Hypostatic congestion — Duration 6d
Due to: Bring bed ridden — 14
Due to: Injuries received in accidental fall

Other conditions (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 About 3 month prior
(c) Where did injury occur? In his room (City or town) (County) (State)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? In his room (Specify type of place)
While at work? No (c) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY