

No. 5-17-39
X32873

Registration District No. 310

Primary Registration District No. 3058

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3
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County St. Charles
(b) City or town St. Charles
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1015 North Fourth St.
(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)

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

Infant James R. Mahan

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 single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: November 3 1942
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 0 0 4 hr. 30 min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Olivet Mahan
13. Birthplace St. Peters Mo
(City, town, or county) (State or foreign country)
14. Maiden name Emma Schlueter
15. Birthplace Stutzville Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Ollie Mahan

(b) Address 1015 N. Fourth, St. Charles, Mo

17. (a) Burial (b) Date thereof Nov 4-1942
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Charles Burial Home Cemetery

18. (a) Signature of funeral director H.C. Dallymeyer & Sons

(b) Address 201 N. Second, St. Charles, Mo

19. (a) 11-4-42 (b) Coarona A. Wessler
(Date received local registrar) (Registrar's Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November 3
year 1942 hour 9 minute 10 P.M.

21. I hereby certify that I attended the deceased from Nov. 3, 1942
4:40 p.m., 1942 to 5:10 p.m. - Nov 3, 1942
that I last saw him alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death: Prematurity
6 1/2 months
Duration _____

Due to _____

Due to _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: 159
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?

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

23. Signature Dr. F. L. Harrington (M.D. or other) DO
Address St. Charles, Mo Date signed Nov 16 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 37908
Registrar's No. 413

Registration District No. 310 Primary Registration District No. 3058

1. PLACE OF DEATH:

(a) County St Charles
(b) City or town St Charles
(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
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. W. Emerson
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Infant James R. Maher
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
year _____ hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

Due to _____

Due to _____

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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

SUPPLEMENTARY

