No. 2
-5-42
5-17-39
X32873

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

3629

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 10 1943

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 2

97 6 0

1. PLACE OF DEATH:
(a) County Saline
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Fitzgibbons Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days (Specify whether years, months or days)
In this community

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

97 0 0

3. (a) PRINT FULL NAME Margaret Ann Dougan
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex female
5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Geo Dougan
6. (c) Age of husband or wife if alive years
7. Birth date of deceased June 22 1868 (Month) (Day) (Year)
8. AGE: Years 74 Months 6 Days 8 If less than one day hr. min.
9. Birthplace Curcilville Ohio (City, town, or county) (State or foreign country)
10. Usual occupation house wife
11. Industry or business
FATHER 12. Name Andrew Horgan
13. Birthplace Ireland (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name Mary Lynch
15. Birthplace Ireland (City, town, or county) (State or foreign country)
16. (a) Informant Mr Geo Dougan
(b) Address Shackelford Mo.
17. (a) burial (Burial, cremation, or removal) (b) Date thereof Dec 30 42 (Month) (Day) (Year)
(c) Place: burial or cremation Ridge Park Shackelford
18. (a) Signature of funeral director Don Short
(b) Address Marshall Mo.
19. (a) 1-5-43 (Date received by local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 30 year 1942 hour minute M.
21. I hereby certify that I attended the deceased from Oct 17 1942 to Dec 30 1942 that I last saw him alive on Dec 29 1942 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Myocarditis	
Due to: Arteriosclerosis	1 1/2 yr
Due to: Hypertension	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

93d

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 Robert Lynn (M. D. or other)
Address Marshall Date signed 1/2/43

12/5

(Licensed Embalmer's Statement on Reverse Side)

District Health Officer No. 8,

District File Number .....

Date Filed 2-9-43

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 Donald W. Short

Licensed Embalmer No. 3757

P. O. Address Marshall 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
I—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 3629

Registration District No. 324 Primary Registration District No. (3072) Registrar's No. 2

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

1. PLACE OF DEATH:

(a) County: Jackson

(b) City or town: Raytown (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Fitzgibbon 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:

(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: Margaret Ann Dougan

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

3. (c) Social Security No. .....

4. Sex: F

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: June (Month) 22 (Day) ..... (Year)

8. AGE: Years 74 Months 4 Days ..... If less than one day: ..... hr. ..... min.

9. Birthplace: Ohio (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) Mrs T. O. Wheelbrook (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. Day 30 year 1942 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19.....; that I last saw h... alive on ..... 19.....; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
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) .....

(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 ..... (M. D. or other) .....

Address ..... Date signed .....

SUPPLEMENTARY