

FILED MAY 11 1944

Registration District No. 100

Primary Registration District No. 5446

1. PLACE OF DEATH:

(a) County Shelby Co Cooper Inf
(b) City or town Shelby 510 N. 2nd St
(c) Name of hospital or institution: HO 111 -
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ✓
In this community 65 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Shelby
(c) City or town Shelby Road B 8
(d) Street No. 719 Shelby 2 MI
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country NO

3. (a) PRINT FULL NAME

Mr Morris EGAN

3. (b) If veteran, name war ✓

3. (c) Social Security No. 110110

4. Sex Male 5. Color or race 0

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife Mrs Margaret E Egan 6. (c) Age of husband or wife if alive 29 years

7. Birth date of deceased MAR 14 29 - 1858
(Month) (Day) (Year)

8. AGE: Years 86 Months 1 Days 0 If less than one day ✓ hr. min.

9. Birthplace Co. Harey Ireland 4
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer - retired

11. Industry or business (FARM)

12. Name (Mk)

13. Birthplace Co Harey Ireland 4
(City, town, or county) (State or foreign country)

14. Maiden name Mk

15. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Ed. Deaton

(b) Address Shelby, Mo

17. (a) Buried (b) Date thereof 4-30-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Columba's Cemetery Mo

18. (a) Signature of funeral director Walter H. Phillips

(b) Address Shelby, Mo

19. (a) 4-20-44 (b) Harold N. Deaton
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 29 year 1944 hour 2 minute 30 A.M.

21. I hereby certify that I attended the deceased from May 4 1944 to April 29 1944
that I last saw him alive on 6/24/ April 28 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Inferiority of heart 2 yrs

Due to Senility

Due to Cardiac insufficiency 72

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 13/a
Of autopsy

Duration

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? _____

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

23. Signature N. J. McEligan (M. D. or other) DO
Address Shelby, Mo Date signed 4-19-44

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

MOTHER FATHER

Dr. R.J. - McIllegan

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 _____

L. A. Phillips

Licensed Embalmer No. 1898

P. O. Address Stebury MD

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.

5

Please write requested information
on the face of the supplemental
and return immediately in the en-
closed franked envelope.

Thank you.

James Stewart Mh

James Stewart, M. D.
Special Agent, Bureau of the Census

Registration District No. 120 Primary Registration District No. 5446

1. PLACE OF DEATH:
(a) County Sentry
(b) City or town Rural Cooper Twp
(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..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Morris Egan
3. (b) If veteran, name war..... 3. (c) Social Security No.

5. Color or race White
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 March 29 1914
(Month) (Day) (Year)

8. AGE: Years 86 Months 1 Days (less than one day) min.

9. Birthplace Ireland
(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) (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).....

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.....

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April 9
year 1944 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.....

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) (e) Means of injury.....

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

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

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

SUPPLEMENTARY

MOTHER FATHER

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