

FILED JUL 7 1944
Registration District No. _____

Primary Registration District No. 1500

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

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital No 2
(If not in hospital or institution, write street number or location) 2
(d) Length of stay: In hospital or institution 3 Mo. 7 day
(Specify whether years, months or days) ?

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Kansas City Mo
(If outside city or town limits, write "RURAL") ?
(d) Street No. ? (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country. 0

3. (a) PRINT FULL NAME

William McLaughlin

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 divorced
6. (b) Name of husband or wife ? 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb. 13 1906
(Month) (Day) (Year)

8. AGE: Years 38 Months 4 Days 15 If less than one day _____ hr. _____ min.

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

10. Usual occupation Cook

11. Industry or business _____

MOTHER FATHER { 12. Name John P. McLaughlin
13. Birthplace England 4
(City, town, or county) (State or foreign country)
14. Maiden name Mary Graham
15. Birthplace England 4
(City, town, or county) (State or foreign country)

16. (a) Informant Ricard - Hospital

(b) Address St Joseph Mo

17. (a) Removal (b) Date thereof 6-28-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Independence Kans

18. (a) Signature of funeral director Fleeman & Son Inc

(b) Address St Joseph, Mo

19. (a) 6/28/44 (b) Robert P. Kelly
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 28
year 1944 hour 5-15 minute 0 M.

21. I hereby certify that I attended the deceased from 3/21 1944 to 6-28 1944
that I last saw him alive on June 28 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis

Due to _____

Due to _____

Other conditions. (Include pregnancy within 3 months of death) 13 1/2

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 W. S. Salzer (M. D. or other) 0

Address St Joseph Mo Date signed _____

Duration
Physician
Underline the cause to which death should be charged statistically.

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