

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6843**
Registrar's No. **6**

FILED FEB 18 1946
Registration District No. _____

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:
St. Joseph
not in hospital or institution, write street number & location)
(d) Length of stay: In hospital or institution **4 1/2 hrs 30 M.** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **St. Charles 92**
(c) City or town **Wentzville**
(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 _____

3. (a) PRINT FULL NAME **Thomas Callahan**

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 **S.O.**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Oct 10 1904**
(Month) (Day) (Year)

8. AGE: Years **41** Months **2** Days **30** If less than one day hr. _____ min. _____

9. Birthplace **Wentzville Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

MOTHER FATHER
12. Name **Thomas Callahan**
13. Birthplace **St. Louis Mo.**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary Murphy**
15. Birthplace **Wentzville Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mary Callahan**
(b) Address **Wentzville**

17. (a) **Burial** (b) Date thereof **Jan 14 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Wentzville**
18. (a) Signature of funeral director **J. P. Peterson**
(b) Address **Wentzville Mo.**

19. (a) **Jan 24 1946** (b) **F. Annie Hamilton**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **9th** year **1946** hour **3:30** minute _____ P. 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.

Immediate cause of death **Acute influenzal pneumonia** Duration _____

Due to _____

Due to _____

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

Major findings: Of operations _____ Of autopsy **yes- 3/30** 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 **2**

23. Signature **Mary Murphy** (b) **F. Annie Hamilton**
Address **Wentzville Mo.** Date signed **1-11-46**

WRITE PLAINLY—USE UNFADING INK—MAKE A PERMANENT RECORD

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 2-15-46

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.....

R. P. [Signature]

Licensed Embalmer No. 3711

P. O. Address Wentzville, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. M 9-2

Registration District No. 310

Primary Registration District No. 3058

Registrar's No. 36

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. _____
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME

Thomas Callahan

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 (Single)

6. (b) Name of husband or wife Not married

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

7. Birth date of deceased Oct 10
(Month) (Day) (Year)

8. AGE: Years 41 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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
 (b) Address _____
 19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month _____
 year 1946 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ 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 _____

Duration _____

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)
 (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 _____ (M. D. or other) _____
 Address _____ Date signed _____

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

SUPPLEMENTARY

6843