

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 St Joseph Hospital  
(If not in hospital or institution, write street number and location)

(d) Length of stay 4 days  
(Specify whether in hospital or institution)

In this community Life  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Buchanan

(c) City or town St Joseph  
(If outside city or town limits, write "RURAL")

(d) Street No. 320 Polith 18  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JAMES-G-McGAUGHEY

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male 5. Color or race Whl

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 April 4 - 1947  
(Month) (Day) (Year)

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

0 7 \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation None

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Chester B. Mc Gaughey

13. Birthplace Plattsburg Mo  
(City, town or county) (State or foreign country)

14. Maiden name Virginia May Bellis

15. Birthplace St Joseph Mo  
(City, town or county) (State or foreign country)

16. (a) Informant Chester B. Mc Gaughey

(b) Address St Joseph

17. (a) B (b) Date removed May 12 - 47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation ashland Cem

18. (a) Signature of funeral director St Joseph

(b) Address St Joseph

19. (a) 5-13-47 (b) W. B. Jenkins  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 11  
year 1947 hour 6:40 minute a M.

21. I hereby certify that I attended the deceased from April 17  
4 1947 to May 10 1947

that I last saw him alive on May 10 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death acute gastroenteritis  
Prematurity

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions None  
(Include pregnancy within 3 months of death)

Major findings: 59  
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 \_\_\_\_\_

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? \_\_\_\_\_ (b) Means of injury \_\_\_\_\_

23. Signature H. B. Petersen (M. D. or other) \_\_\_\_\_

Address St Joseph Mo Date signed 5-12-47

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

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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.....

Charles Marshall Harmon, Registered Apprentice No. 450  
working under my personal supervision.

Signed John G. Hurley

Licensed Embalmer No. 4050

P. O. Address St Joseph, 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.**