S. No. 2
1—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
Public Health Service

FILED AUG 26 1947

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 26750

Registration District No. 38 | Primary Registration District No. 3006 | Registrar's No. 218

1. PLACE OF DEATH:

(a) County: Boone
(b) City or town: Columbia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1106 W. Ash St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 60 Years (Specify whether years, months or days)
In this community:

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Boone
(c) City or town: Columbia
(If outside city or town limits, write "RURAL")
(d) Street No.: 1106 W. Ash St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: JAMES ROBERT MAHANEY

3. (b) If veteran, name war: None

3. (c) Social Security No.: None

4. Sex: Male

5. Color or race: White

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

6. (b) Name of husband or wife: Unknown

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

7. Birth date of deceased: 4 (Month) - 2 (Day) - 1861 (Year)

8. AGE: Years: 86 | Months: 4 | Days: 8 | If less than one day: hr. min.

9. Birthplace: Ireland (City, town, or county) (State or foreign country)

10. Usual occupation: Retired

11. Industry or business:

MOTHER / FATHER

12. Name: Unknown
13. Birthplace: Unknown (City, town, or county) (State or foreign country)

14. Maiden name: Unknown
15. Birthplace: Unknown (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. L.E. Rhyne
(b) Address: Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8-12-47 (Month) (Day) (Year)
(c) Place: burial or cremation: Columbia Cemetery

18. (a) Signature of funeral director: Parker Funeral Service
(b) Address: Columbia, Mo.

19. (a) 8-16-47 (Date received local registrar) (b) Mrs. R.E. Palmer (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Aug. day: 10
year: 1947 hour: minute: M.

21. I hereby certify that I attended the deceased from June - 1947 to Aug - 10 1947
that I last saw him alive on Aug 10 1947
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Myocarditis - Chronic	10 yrs
Due to:	
Due to:	
Other conditions: Cardiac Asthma (Include pregnancy within 3 months of death)	1 yr

Major findings:
Of operations:
Of autopsy:

PHYSICIAN — Underline the cause of 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: F. C. Suggett (M. D. or other) M.D.
Address: Columbia Date signed: 8/11/47.

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer, No. 9,
District File Number
Date Filed 8-27-42

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 Tom McHaney

Licensed Embalmer No. 4067

P. O. Address Columbia 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.