FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED AUG 17 1948

Registration District No. 347

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 4508

State File No. 28621

Registrar's No. 36

1. PLACE OF DEATH:
(a) County Stone
(b) City or town Galena
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 9
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community About 30 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Stone 10
(c) City or town Galena
(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 Allen McQuary
3. (b) If veteran, name war ✓
3. (c) Social Security No. ✓
4. Sex M
5. Color or race Wh
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Naoma McQuary
6. (c) Age of husband or wife if alive 53 years
7. Birth date of deceased Nov (Month) 3 (Day) (Year)

8. AGE: Years 77 Months 8 Days 24 If less than one day hr. min.

9. Birthplace Carthage (City, town, or county) Ill (State or foreign country)
10. Usual occupation Post master
11. Industry or business Roof Binder
FATHER
12. Name Allen Lucian
13. Birthplace (City, town, or county) Ill (State or foreign country)
MOTHER
14. Maiden name Alice Kendrick
15. Birthplace (City, town, or county) Missouri (State or foreign country)
16. (a) Informant Mrs. Naoma McQuary
(b) Address Galena Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-28-48 (Month) (Day) (Year)
(c) Place: burial or cremation Galena Mo.
18. (a) Signature of funeral director Everett J Cheatham
(b) Address Galena Mo.
19. (a) Aug 2-48 (Date received local registrar) (b) Lena Murray-Dep. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 27 year 1948 hour 11 minute 45 A.M.
21. I hereby certify that I attended the deceased from at death 7-27 1948 to July 27 1948; that I last saw him alive on July 27 1948; and that death occurred on the date and hour stated above.

Immediate cause of death Gun Shot
He Shot him self through the head with a 38 Cal pistol.
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

Duration

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) Suicide
(b) Date of occurrence July 27-1948
(c) Where did injury occur? Galena (City or town) Stone (County) Mo (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Back of post office (Specify type of place)
While at work? yes (e) Means of injury Gun Shot
23. Signature Everett J Cheatham (M. D. or other) Coroner
Address Galena Mo. Date signed 7-31-48

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

WHITE PAPER—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
District Health Officer No. 6
District File Number 848-924
Date Filed AUG 16 1948

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 Everett J. Cheatham

Licensed Embalmer No. 3870

P. O. Address Galena 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.

. 2B
3-45
X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Sept

Registration District No. 347 Primary Registration District No. 4508 Registrar's No.

1. PLACE OF DEATH:

(a) County Stone

(b) City or town Galena
(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 years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Stone

(c) City or town Galena,
(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 A. McQuary

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 M

6. (b) Name of husband or wife

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

7. Birth date of deceased Nov 3 1878
(Month) (Day) (Year)

8. AGE: Years 77 Months 8 Days 3 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

MOTHER
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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day year hour minute 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	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

SUPPLEMENTARY

28621