

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED AUG 2 - 1955

State File No. ....

318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 5708

BIRTH NO. _____				REG. DIST. NO. _____				PRIMARY REG. DIST. NO. 1003				Registrar's No. 5708							
1. PLACE OF DEATH a. COUNTY _____								2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Illinois</u> b. COUNTY <u>Macoupin</u>											
b. CITY (If outside corporate limits, write RURAL and give town) <u>ST. LOUIS, MISSOURI</u>				c. LENGTH OF STAY (In this place) _____				c. CITY OR TOWN <u>Wilsonville</u>				d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>							
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>								e. STREET ADDRESS (If rural, give location) _____											
3. NAME OF DECEASED (Type or Print) a. (First) <u>JAMES</u>				b. (Middle) <u>B.</u>				c. (Last) <u>GAHAGAN</u>				4. DATE OF DEATH <u>July 1, 1955</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Sept 20 1896</u>		9. AGE (In years last birthday) <u>58</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coal Miner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Mining</u>				11. BIRTHPLACE (City and State or Foreign Country) <u>Hornsby, Illinois</u>				12. CITIZEN OF WHAT COUNTRY? <u>U..S.A.</u>							
13a. FATHER'S NAME <u>Joseph Gahagan</u>				13b. MOTHER'S MAIDEN NAME <u>Margaret Carroll</u>				14. NAME OF HUSBAND OR WIFE <u>Elizabeth Gahagan</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No Nil</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>				17. INFORMANT'S SIGNATURE OR NAME <u>Elizabeth Gahagan, Wilsonville, Ill</u>				ADDRESS _____							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.								I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Malignant Brain Tumor--Left Temporal Lobe</u>								INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u>			
ANTECEDENT CAUSES  Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____								II. OTHER SIGNIFICANT CONDITIONS  Conditions contributing to the death but not related to the disease or condition causing death.											
19a. DATE OF OPERATION <u>6-9-55</u>				19b. MAJOR FINDINGS OF OPERATION <u>FINDINGS AS ABOVE</u>								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____				21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____				21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____											
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____				21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21f. HOW DID INJURY OCCUR? <u>193x</u>											
22. I hereby certify that I attended the deceased from <u>6-2</u> , 19 <u>55</u> , to <u>7-1-55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>7-1</u> , 19 <u>55</u> , and that death occurred at <u>4:20 pm.</u> , from the causes and on the date stated above.																			
23a. SIGNATURE <u>Carl Smith, M.D.</u> (Degree or title) <u>M. D.</u>								23b. ADDRESS <u>BARNES HOSPITAL</u>				23c. DATE SIGNED <u>7-2-55</u>							
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				24b. DATE <u>7-2-55</u>				24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>				24d. LOCATION (City, town, or county) (State) <u>Carlinville, Illinois</u>							
DATE REC'D BY LOCAL REG. <u>JUL 2 1955</u>				REGISTRAR'S SIGNATURE <u>Carl Smith</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>Albert H. Hoppe</u>				ADDRESS <u>4700 Washington</u>							

WRITE PLAINLY—USING 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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed..... *Paul A. Wachte* .....

Licensed Embalmer No. *47* .....

P. O. Address *St. Louis* .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.