

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

2956

542

**1. PLACE OF DEATH**

County.....  
Township.....  
City..... *St. Louis*

Registration District No. *791*  
Primary Registration District No. *1003*

File No. ....  
Registered No. *9* *Cancer Hospital* Ward

**2. FULL NAME** *Charles B. Maughan*

(a) Residence, No. *4300 Lindell St.*, *19* Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Widowed*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Louisa*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Sept 16, 1869*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
*57* | *3* | *27*

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work *Librarian*  
(b) General nature of industry, business, or establishment in which employed (or employer) *St. Louis Post Dispatch*  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN; STATE OR COUNTRY) *Des Moines Iowa*

10. NAME OF FATHER *John K. Maughan*

11. BIRTHPLACE OF FATHER (CITY OR TOWN; STATE OR COUNTRY) *England*

12. MAIDEN NAME OF MOTHER *Martha L. Stout*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN; STATE OR COUNTRY) *Indiana*

14. INFORMANT (Address) *Jack Maughan 4300 Lindell*

15. FILED *JAN 16 1927* *Max B. Starvo* REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *1-13-27* 19

17. I HEREBY CERTIFY, That I attended deceased from *11-5-26*, 19, to *1-13-27*, 19, that I last saw him alive on *1-13-27*, 19, and that death occurred, on the date stated above, at *10:45 P.M.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*Carcinoma of Esophagus*  
*Advanced*  
*46A* (duration) yrs. *10* mos. ds.  
*110A* (SECONDARY) *Perforation of Esophagus*  
*into Trachea* (duration) yrs. mos. ds. *3*

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? *St. Louis*

1 DID AN OPERATION PRECEDE DEATH? *Yes* DATE OF *9-11-26*

WAS THERE AN AUTOPSY? *Yes*

WHAT TEST CONFIRMED DIAGNOSIS? *Autopsy - Clinical*

(Signed) *C. M. Emery*, M. D. *1-14, 1927* (Address) *Barnard Hospital*

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Mount Hope* DATE OF BURIAL *Jan 16 1927*

20. UNDERTAKER *Chapman & Co* ADDRESS *7864 S. B. Hwy*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

