

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

Do not use this space.

34618

PLACE OF DEATH

County *St. Louis*
Township
City *Richmond*

Registration District No. *790*
Precinct Registration District No. *2033*
(No. *St. Marys Hospital*)

File No.
Registered No. *827*
St. _____ Ward _____

2. FULL NAME

James Mc Mahon
(a) Residence. No. _____ St. _____ Ward. *Gillespie 2d*
(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. *19* da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Apr. 19th 1864*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. *63 7 6*

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Scotland*

10. NAME OF FATHER *James Mc Mahon*

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

12. MAIDEN NAME OF MOTHER *Catherine Phoe*

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

14. INFORMANT (Address) *St. Marys Hospital
Clayton Row*

15. FILED *11/28* 19. *27* *J. B. Sudduth* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *11-25-1927*
17. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____ that I last saw him alive on _____ 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of Stomach

CONTRIBUTORY (SECONDARY) *Intestinal Distention with peritonitis*
(duration) yrs. mos. d. *4* da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? DATE OF _____
WAS THERE AN AUTOPSY? *Yes* DATE OF *Nov 27*

WHAT TEST CONFIRMED DISEASE? *Autopsy*
(Signed) _____ M. D.
11/25, 1927 (Address) _____

*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 *Gillespie 2d* DATE OF BURIAL *11-27-1927*

20. UNDERTAKER *Union Funeral Home* ADDRESS *Gillespie 2d*

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.

DEPARTMENT RECORD

1928

6

MAR 20 1947