

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.

SEP 12 1939

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

29606
Do not use this space.

1. PLACE OF DEATH
 (a) County Livingston Registration District No. 508
 (b) Township..... Primary Registration District No. 3026 Registered No. 101
 (c) City Chillicothe (d) Street No. St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME William T. McCloughan
 (a) Residence, No. 423 Blay St. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb. 16, 1858

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>81</u>		<u>6</u>	<u>3</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Harness Maker

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Warsaw, Indiana (STATE OR COUNTRY)

FATHER

13. NAME Ira McCloughan

14. BIRTHPLACE (CITY OR TOWN) Indiana (STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME Catherine Sellers

16. BIRTHPLACE (CITY OR TOWN) Indiana (STATE OR COUNTRY)

17. INFORMANT Lugen McCoy (ADDRESS) Chillicothe, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Utica Cem. DATE Aug. 9, 1939

19. FUNERAL DIRECTOR (NAME) James Gordon (ADDRESS) Chillicothe, Mo.

20. FILED 8-8- 1939 Arnold M. D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug - 7 - 1939

22. I HEREBY CERTIFY, That I attended deceased from Mar 5 - 1936 to Aug 7 - 1939
 I last saw him alive on Aug 6 - 1939. Death is said to have occurred on the date stated above, at 9:30 m.
 The principal cause of death and related causes of importance were as follows:
Chronic Interstitial nephritis Date of onset about 1930

Other contributory causes of importance:
121

Name of operation None Date of
 What test confirmed diagnosis Clinical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Date of injury....., 19.....
 Where did injury occur? (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify
 (Signed) W. Carpenter, M. D.
 (Address) Chillicothe, Mo.

RECEIVED

District Health Officer No. 11

District File No. 939-1144

Date Filed SEP 8 1939

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 *James D. Gordon*

Licensed Embalmer No. 1870

P. O. Address Chillicothe, 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, above space should be left blank.