

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

NOV 24 1939

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

37286  
Do not use this space.

1. PLACE OF DEATH

(a) County Saline Registration District No. 79639  
(b) Township 3 Primary Registration District No. 3039  
(c) City Marshall (d) Street No. Mo State School Registered No. 172  
(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. 11 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 250 Paul Kegan St.  (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 11, 1911

7. AGE YEARS 28 MONTHS 1 DAYS 15 IF LESS than 1 day, hrs. or min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None  
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) (STATE OR COUNTRY) St. Joseph, Mo

FATHER 13. NAME Owen J. Kegan  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Atchinson, Kansas

MOTHER 15. MAIDEN NAME Mary E. Pearce  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Joseph, Mo

17. INFORMANT (ADDRESS) School Record Marshall

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Joseph, Mo DATE Oct 26th 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) H. O. Sidenaden & Co. St. Joseph, Mo. 1802 Union

20. FILED 10-26-39 Mary Kent Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 26, 1939

22. I HEREBY CERTIFY, That I attended deceased from March 5, 1928 to Oct 26, 1939  
I last saw him alive on Oct. 26, 1939 Death is said to have occurred on the date stated above, at 1400 m.  
The principal cause of death and related causes of importance were as follows:  
Pulmonary tuberculosis  
Date of onset 73

Other contributory causes of importance:

Name of operation None Part of None  
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) Mary Kent M. D.  
(Address) Marshall

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 11/13/39

**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 *Robert P. Carlson*

Licensed Embalmer No. *4028*

P. O. Address *1802 Union,*

**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.**