S. No. 2
M—2-43
5-17-39
FILED AUG 30 1943

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 26540

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7571

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County ~~XXXXXXXXXXXXXXXX~~

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 0 BARNES HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Webster 112 0

(c) City or town Seymour 0 N.R.
(If outside city or town limits, write "RURAL")

(d) Street No. Rural Route #1.
(If rural, give location)

(e) Citizen of foreign country? 1 (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Caughran, Ralph

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race 0 White

6. (a) Single, widowed, married, divorced 1 Married

6. (b) Name of husband or wife Oda Caughran

6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased July (Month) 7 (Day) 1885 (Year)

8. AGE: Years 58 Months 1 Days 14 If less than one day ..... hr. ..... min.

9. Birthplace Webster County (City, town, or county) Missouri 0 (State or foreign country)

10. Usual occupation Rural School Teacher

11. Industry or business .....

FATHER
12. Name John Caughran
13. Birthplace Unknown (City, town, or county) Missouri 0 (State or foreign country)

MOTHER
14. Maiden name Lucinda Haymes
15. Birthplace Unknown (City, town, or county) Missouri 0 (State or foreign country)

16. (a) Informant Oda Caughran
(b) Address Seymour, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/43 (Month) (Day) (Year)
(c) Place: burial or cremation Seymour, Missouri

18. (a) Signature of funeral director Albert H. Hoppe, Inc
(b) Address 4700 Washington Blvd.

19. (a) AUG 2 1943 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

AUG 24 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 21 year 1943 hour 8 minute — A. M.

21. I hereby certify that I attended the deceased from Aug. 12, 1943, to Aug. 21, 1943 that I last saw him alive on Aug. 21, 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Carcinoma of the lung	9 mos.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) .....

(b) Date of occurrence .....

(c) Where did injury occur? ..... (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? ..... (Specify type of place)

While at work? ..... (e) Means of injury .....

23. Signature M. C. Abney (M. D. or other)

Address BARNES HOSPITAL Date signed 8/21/43

(Licensed Embalmer's Statement on Reverse Side)

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 .....

Licensed Embalmer No. .....

P. O. Address .....

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, fact should be so stated above.