

S. No. 2
M-1-4-41
v. 5-17-39
X28390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **30001**
Registrar's No. **7182**

FILED SEP 23 1946
Registration District No. **120**

Primary Registration District No. **2000**

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

1. PLACE OF DEATH:
(a) County **Greene**
(b) City or town **Springfield Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
~~known as batchlers INN~~ **BURGER-GONIVELLY**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **6 Months** Rest Home
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Greene**
(c) City or town **Republic**
(If outside city or town limits, write "RURAL")
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Michael Eagan**
3. (b) If veteran, name war **UNK**
3. (c) Social Security No. **UNK**

MEDICAL CERTIFICATION
20. DATE OF DEATH, Month **Sept**, day **2**, year **1946**, hour **12**, minute **30 P.M.**

4. Sex **male** Color or race **White**
5. (a) Single, widowed, married, divorced **MARRIED**
6. (b) Name of husband or wife **Elsie EAGAN**
6. (c) Age of husband or wife if alive **UNK** years
7. Birth date of deceased **July 30, 1871**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Unattended by physician**, 19____, that I last saw him _____ alive on _____, and that death occurred on the date and hour stated above.

8. AGE: Years **75** Months **1** Days **2**
If less than one day _____ hr. _____ min.

Immediate cause of death **probably coronary occlusion**
Due to _____
Due to _____

9. Birthplace **Franks Switch Mo. Missouri**
(City, town, or county) (State or foreign country)

Other conditions _____
(Include pregnancy within 3 months of death)

10. Usual occupation **Railroader**

Major findings: **94A**
Of operations _____
Of autopsy _____

11. Industry or business **Section Foreman**

MOTHER FATHER { 12. Name **Patric Eagan**
13. Birthplace **Ireland UNK. IRELAND**
(City, town, or county) (State or foreign country)
14. Maiden name **Catharyne McGee**
15. Birthplace **Ireland UNK. IRELAND**
(City, town, or county) (State or foreign country)

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

16. (a) Informant **Edgar M Eagan**
(b) Address **Jefferson City, SPED., Mo.**

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? _____

17. (a) **burial** (Burial, cremation, or removal) (b) Date thereof **9-4-46**
(Month) (Day) (Year)
(c) Place: burial or cremation **Evergreen cemetery**

18. (a) Signature of funeral director **R.E. Thurman**
(b) Address **9-5-46 Republic, Mo.**

While at work? _____ (Specify type of place)
(e) Means of injury _____

19. (a) **9-5-46** (Date received local registrar) (b) **W.S. Handley M.D.** (Registrar's signature)

23. Signature **W.S. Handley** (M. D. or other) **Local Registrar**
Address **Springfield, Mo.** Date signed **9/5/46**

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.