

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.

How
MAY 22 1939

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

15982

Do not use this space.

1. PLACE OF DEATH
(a) County St. Francis Registration District No. 775
(b) Township St. George Primary Registration District No. 6030-A
(c) City Bonne Terre Mo (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. ds.
2. PRINT FULL NAME Patrick Francis McMahon
(a) Residence, No. Bonne Terre Mo 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 <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Mary Ann McMahon</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Feb. 10. 1857</u>		
7. AGE	YEARS <u>82</u>	MONTHS <u>2</u>
	DAYS <u>14</u>	IF LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as a lawyer, bookkeeper, etc. <u>Retired</u>	11. Total time (years) spent in this occupation _____
	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) _____	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Buckskue Illinois</u>		
FATHER	13. NAME <u>Patrick McMahon</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ireland</u>	
MOTHER	15. MAIDEN NAME <u>Catherine Shields</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ireland</u>	
17. INFORMANT (ADDRESS) <u>Flora McMahon</u> <u>Bonne Terre Mo</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>St. Joseph's Cemetery</u> <u>April 26 1939</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Sanford Ford Co</u> <u>Bonne Terre Mo</u>		
20. FILED <u>4-26-1939</u> <u>N. W. Hawkins</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 24 1939

22. I HEREBY CERTIFY, That I attended deceased from April 15 1939 to April 22 1939
I last saw h. j. m. alive on April 22 1939. Death is said to have occurred on the date stated above, at 5 P. m.
The principal cause of death and related causes of importance were as follows:
Chronic myocarditis
A3C
Date of onset 1930

Other contributory causes of importance:
arteriosclerosis 1935
upper respiratory infection April 1935

Name of operation None Date of _____
What test confirmed diagnosis? blurred 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) Martin J. How, M. D.
(Address) Bonne Terre, Mo,

BY THE BOARD OF EXAMINERS
FOR THE BOARD OF HEALTH
OF THE STATE OF MISSISSIPPI

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, O. J. Claywell, or by _____

Registered Apprentice No. _____, working under my personal supervision.

Signed O. J. Claywell
Licensed Embalmer No. 3706
P. O. Address Bound Brook, Miss.

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.