

Registration District No. 744

Primary Registration District No. 5976 B

Registrar's No. 48

1. PLACE OF DEATH: Ray 7211
(a) County Ray
(b) City or town Rural
(c) Name of hospital or institution: Farm Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2
In this community all his life (Specify whether years, months or days)

3. (a) PRINT FULL NAME JAMES MADISON MCGAUGH
8. (b) If veteran, name war _____ 3. (c) Social Security No. none

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Eda McGaugh 6. (c) Age of husband or wife if alive 73 years
7. Birth date of deceased 5 16 1856
(Month) (Day) (Year)

8. AGE: Years 83 Months 11 Days 22
If less than one day _____ hr. _____ min.

9. Birthplace Ray, Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHERS
12. Name Mathey W. S. Gaugh
13. Birthplace Ireland
(City, town, or county) (State or foreign country)
14. Maiden name Betty Holman
15. Birthplace Don't know
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature A. B. McGaugh
(b) Address Rayville, Mo
17. (a) Buried (b) Date thereof 5-4-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Cranberry

18. (a) Signature of funeral director J. B. Broadhurst
(b) Address Rayville, Mo

19. (a) May 13 - 40 (b) Mabel Jackson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Ray
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Farm
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 2
year 1940 hour 1:45 minute P. M.
21. I hereby certify that I attended the deceased from mail
_____ 1940, to May 2, 1940;
that I last saw him alive on May 2, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death: Aut. Pulmonary Edema Duration 12 hrs.

Due to Chronic Myocarditis

Due to Chronic Glomerulonephritis

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

Major findings: _____
Of operations _____
Of autopsy _____

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?
While at work? _____ (Specify type of place)
Means of injury _____
23. Signature Dr. H. DeCham (M. D. or other) _____
Address Willington Mo Date signed 5/13/40

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.

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 6-14-40

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.....

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

Signed *J. E. Broadhurst*
Licensed Embalmer No. *2171*
P. O. Address *Rayville, 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.