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.

PLACE OF DEATH

County: Perry

Township: Sling
or
Village:
or
City: (NO. , St.; Ward)

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

Registration District No. 6587 9

Primary Registration District No. 9879

File No. 5649

Registered No. 40

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME William McGill

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

DATE OF BIRTH: March 12, 1858 (Month) (Day) (Year)

AGE: 56 yrs. 8 mos. 22 ds. If LESS than 1 day, hrs. or min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): Farm work

BIRTHPLACE (City or town, State or foreign country): St. Francis Co Mo

PARENTS
NAME OF FATHER: George McGill
BIRTHPLACE OF FATHER (City or town, State or foreign country): Ireland
MAIDEN NAME OF MOTHER: Don't know
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ireland

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Harry McGill
(ADDRESS): Lithium Mo.

Filed 1/4 1915 [illegible]
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: Jan 4th, 1915 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Dec 1st, 191, to , 191, that I last saw him alive on , 191, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage due to Arteriosclerosis, Chronic Nephritis, Chronic Myocarditis, Contributory Senile Dementia

(Duration) yrs. mos. ds.

Contributory (SECONDARY)
(Duration) yrs. mos. ds.

(Signed) Dr. Jno. A. Blayloch M.D.
1/4 1915 Address Perryville Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence

PLACE OF BURIAL OR REMOVAL: St Mango Mo
DATE OF BURIAL: 1/6 1915
UNDERTAKER: John Rond
ADDRESS: St Mango Mo

PLACE OF DEATH

County .....

Township ..... or

Village ..... or

City ..... (NO. .... St.; ..... Ward)

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

Registration District No. ..... File No. .....

Primary Registration District No. ..... Registered No. .....

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

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.

PERSONAL AND STATISTICAL PARTICULARS

SEX | COLOR OR RACE | SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

DATE OF BIRTH ..... (Month) ..... (Day), 1..... (Year)

AGE ..... yrs. ..... mos. ..... ds. | If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE (City or town, State or foreign country) .....

PARENTS
- NAME OF FATHER .....
- BIRTHPLACE OF FATHER (City or town, State or foreign country) .....
- MAIDEN NAME OF MOTHER .....
- BIRTHPLACE OF MOTHER (City or town, State or foreign country) .....

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ..... 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH ..... (Month) ..... (Day), 191..... (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....,
that I last saw h..... alive on ....., 191.....,
and that death occurred, on the date stated above, at ..... m.
The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191.....

UNDERTAKER | ADDRESS