WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

PLACE OF DEATH

County Pettis

Township ____ or Village ____ or City Sedalia (NO. 404-N. Prospect St.; 1st Ward)

Registration District No. 668 File No. 25493

Primary Registration District No. 3032 Registered No. 197

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

FULL NAME George Cannon McLaughlin

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

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

DATE OF BIRTH: April 18th (Month) (Day), 1846 (Year)

AGE: 69 yrs. 4 mos. 12 ds. If LESS than 1 day, ____ hrs. or ____ min.?

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

117 B
11 E

BIRTHPLACE (City or town, State or foreign country): St. Marys Ohio

PARENTS
NAME OF FATHER: George Whitefield McLaughlin
BIRTHPLACE OF FATHER (City or town, State or foreign country): Baltimore Md.
MAIDEN NAME OF MOTHER: Mary Hart
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Conn.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jno McLaughlin

(ADDRESS) Sedalia Mo

Filed Aug 2 1915 F. B. Long REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: July 30 (Month) (Day), 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from July 30, 1915, to July 30, 1915, that I last saw him alive on July 30, 1915, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer (Penetrating) 102

(Duration) ____ yrs. 2 mos. ____ ds.

Contributory (SECONDARY) Chr. Gastritis

(Duration) 10 yrs. ____ mos. ____ ds.

(Signed) K R Barnum M. D.

8/2 1915 (Address) Sedalia

*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: Sedalia Mo. Cemetery

DATE OF BURIAL: Aug-1- 1915

UNDERTAKER: McLaughlin B.

ADDRESS: Sedalia

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

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ..... ; ..... St.; ..... Ward)

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

FULL NAME .....

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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
..... , 1..... (Month) (Day) (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 ..... , 191..... , ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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