

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

Do not use this space.

15591d

1. PLACE OF DEATH

County Ray
Township Waded
City Higginsville (No.)

Registration District No. 460
Primary Registration District No. 5623-B

File No.
Registered No. 46 (St. Ward)

2. FULL NAME

Leslie Ann Allen McCarney
(a) Residence, No. Confidential Home St. Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 2, 1944

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	84	8	29	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employee)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN; STATE OR COUNTRY) Ballston Virginia

10. NAME OF FATHER South Know

11. BIRTHPLACE OF FATHER (CITY OR TOWN; STATE OR COUNTRY) South Know

12. MAIDEN NAME OF MOTHER May Allen

13. BIRTHPLACE OF MOTHER (CITY OR TOWN; STATE OR COUNTRY) Va

14. INFORMANT Margaret McCarney
(Address) 612 No Weber St Cole Spgs Colo

15. FILED 5-31-27 Bessie P. Porter
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 30 1927

17. I HEREBY CERTIFY, That I attended deceased from May 23, 1927, to May 30, 1927, that I last saw him alive on May 30, 1927, and that death occurred, on the date stated above, at 1:00 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Pneumonia
90 B
107A (duration) yrs. mos. 7 ds.
CONTRIBUTORY Chronic Myocarditis
(SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? Confidential Home

19. DID AN OPERATION PRECEDE DEATH? no DATE OF

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) J. DeWine J. Boyd, M. D.
, 19 27 (Address) Higginsville Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Confidential Home Cemetery DATE OF BURIAL 5/31 1927

20. UNDERTAKER W. H. Hagg ADDRESS W. H. Hagg

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.

ATTN 1

