

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

Do not use this space.

27434

1. PLACE OF DEATH

County Jackson
Township Rego
City Kennett

Registration District No. 399
Primary Registration District No. 1007
(Name) Mercy Hospital

File No. _____
Registered No. 65 _____
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. 115 Fairfield St. 9 Ward. _____
(Usual place of abode) (If nonresident give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Eng.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 20 1927

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
2 8

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Kennett
(STATE OR COUNTRY)

10. NAME OF FATHER Clyde R. McCann

11. BIRTHPLACE OF FATHER (CITY OR TOWN) West Point Ia
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Mary Richardson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Keosauqua Ieb
(STATE OR COUNTRY)

14. INFORMANT (Address) Clyde McCann
115 Fairfield

15. FILED 9/28 27 M. M. Corvone REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 28 1927

17. I HEREBY CERTIFY, That I attended deceased from Sept 26, 1927, to Sept 28, 1927, that I last saw deceased alive on Sept 27, 1927, and that death occurred, on the date stated above, at 7:02 am.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia, bronchial

10910
79A 0 (duration) yrs. mos. 2 da.

CONTRIBUTORY (SECONDARY) Otitis media
(duration) yrs. mos. 2 da.

18. WHERE WAS DISEASE CONTRACTED at home
IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Clinical Observation

(Signed) Charles Eldredge, M. D.

Address 701 Rathroff Bldg
Sept 28, 1927

*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 Forest Hill DATE OF BURIAL Sept 28 1927

20. UNDERTAKER R. V. Lindsey ADDRESS City

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.

