

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

Do not use this space.

33826

1. PLACE OF DEATH
 County Polk Registration District No. 407
 Township Polk Primary Registration District No. 4-2-4-1
 City Prosperity, Mo. 5561 St. _____ Ward _____

2. FULL NAME Cubray, David McCaule
 (a) Residence No. _____ Ward _____
 (Usual place of abode) Prosperity, Mo. (If nonresident give city or town and State)
 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** Wh. **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 3 - 1907

7. AGE	YEARS	MONTHS	DAYS	IF LESS than
	<u>20</u>	<u>10</u>	<u>16</u>	day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Miner
 (b) General nature of industry, business, or establishment in which employed (or employer) Quinn's
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Prosperity, Mo.

10. NAME OF FATHER J. A. McCaule

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) McMinn Co., Tenn.

12. MAIDEN NAME OF MOTHER Martha Master

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

14. INFORMANT J. A. McCaule
 (Address) Prosperity, Mo.

15. FILED 11-20-1927 W. L. Gray REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 19 1927

17. I HEREBY CERTIFY, That I attended deceased from Nov. 19, 1927, to Nov. 19, 1927, and that I last saw him alive on Nov. 19, 1927, and that death occurred, on the date stated above, at 7:45 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Myocarditis
938 (duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (SECONDARY) 901B (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH, _____

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
20. WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) L. G. Chenoweth, M. D.
11-18-1927 (Address) Polk, 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 <u>Stirling Cemetery</u>	DATE OF BURIAL 19 _____
20. UNDERTAKER <u>Frank - Deavers</u>	ADDRESS <u>Polk, Mo.</u>

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.

JAN 5

STATE BLIND ASSOCIATION
OCCUPATION IS VERY IMPORTANT

AGP
de Robert

CAUSE OF

1952

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Jasper Registration District No. 407 File No. _____
 Township Golden Primary Registration District No. 5561 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Aubrey Glover McCauley

(a) Residence. No. _____ 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.
 (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

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

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

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____ (duration) yrs. mos. ds.
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

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

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address)

FILED 11-20-27

C. L. Gray
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 19 1927

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.
 , 19____ (Address)

*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 DATE OF BURIAL

Sterling Cemetery Nov 20 1927
 20. UNDERTAKER ADDRESS

1 HOURS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-33826