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

Do not use this space.

33902

File No.
Registered No. ~~29~~ 141

1. PLACE OF DEATH
County: Jasper
Township:
City: Webb City Mo. (No. ..... St. ..... Ward)
Registration District No. 417
Primary Registration District No. 55610

2. FULL NAME John George
(a) Residence. No. Jasper County Tuberculosis Hospital St. ..... Ward ..... (If nonresident give city or town and State)
(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): Single

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

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

7. AGE: about 64 Years | Months | Days | If LESS than 1 day, ..... hrs. or ..... min.

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 employer):
(c) Name of employer:

9. BIRTHPLACE (CITY OR TOWN): Bromwilde
(STATE OR COUNTRY): Missouri

PARENTS
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN):
(STATE OR COUNTRY): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN):
(STATE OR COUNTRY): Unknown

14. INFORMANT: John Hanna
(Address): Webb City Mo.

15. FILED Nov. 7, 1927 R. M. Stormont
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): November 8 1927

17. I HEREBY CERTIFY, That I attended deceased from October 26, 1927, to November 9, 1927, that I last saw ~~living~~ alive on November 2, 1927, and that death occurred, on the date stated above, at 4 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Pulmonary Tuberculosis
23A
(duration) yrs. 3 mos. 15 ds.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? No.
WHAT TEST CONFIRMED DIAGNOSIS? Physical examination
(Signed) Thomas H. Gelmond, M. D
T B Hospital
, 19 (Address) Webb City, Missouri

*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: Mount Hope Cem.
DATE OF BURIAL: 11/7 1927

20. UNDERTAKER: Webb City Und. Co.
ADDRESS: Webb City

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.