

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

Do not use this space.

Rainey
19755

1. PLACE OF DEATH

County *Macon*
Township *Woodland*
City *macon* (N. Ward)

Registration District No. *533*
Primary Registration District No. *3027*

File No. _____
Registered No. *31*

2. FULL NAME

Chas B Gura

(a) Residence. No. _____ St. _____ 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

2. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Sept. 16 - 1885*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
42 6 8

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Tramster*
(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) *Moorely*

10. NAME OF FATHER

Thomas Gura

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) *Unknown*

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) *Unknown*

14.

INFORMANT *Mrs. Chas. Gura*
(Address) *macon*

15.

FILED *13/30 28* *Mrs Luke Hunkler*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *3/24* 19 *28*

17. I HEREBY CERTIFY, That I attended deceased from *Macon* Mo. to *Macon* Mo. on *March 24* 19 *28* that I last saw *him* alive on *March 5* 19 *28*, and that death occurred, on the date stated above, at *5:58 P* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Scarlet fever
59 (duration) yrs. mos. ds. *5/1/28*
CONTRIBUTORY *heart* (SECONDARY) *heart* 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? _____

3/28 (Signed) *A. P. [Signature]*, M. D.
Macon Mo (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

Woodlawn

DATE OF BURIAL

3/26 19 *28*

20. UNDERTAKER

Albert Skinner ADDRESS *macon*

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.

PERMANENT RECORD

1928

42

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