LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

MAR 21 1928

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

10257

PLACE OF DEATH

County Ray — Registration District No. 739 — File No. 10257

Township Camden — Primary Registration District No. 4441 — Registered No.

City — (No. ..... St. ..... Ward)

FULL NAME R G McGill Jr

(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

SEX: male

4. COLOR OR RACE: Colored

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*):

If Married, Widowed, or Divorced: HUSBAND OF (OR) WIFE OF

DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 30-1926

AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
1	11	8	

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

BIRTHPLACE (CITY OR TOWN) Kansas City
(STATE OR COUNTRY) Mo

10. NAME OF FATHER R.G. McGill

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

12. MAIDEN NAME OF MOTHER Verna Stevens

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

INFORMANT R.G. McGill
(Address) Camden Mo

FILED Mar 8-1928 W.W. Burgess REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 7 1928

17. I HEREBY CERTIFY, That I attended deceased from March 7, 1928, to March 7, 1928 that I last saw he alive on March 7, 1928 and that death occurred, on the date stated above, at 10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Colitis

Unknown (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) NONE (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) Geo. S. Pennington, M. D.

3/8, 1928 (Address) Camden 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Camden — DATE OF BURIAL: 3/8 1928

20. UNDERTAKER: F. L. Rowland — ADDRESS: Camden Mo

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No....., ...St. .....Ward)

2. FULL NAME .....

(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

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*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 .....

(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)

PARENTS

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)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....mos.

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).....,

, 19 (Address)

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20. UNDERTAKER | ADDRESS