

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

Do not use this space

17656
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1. PLACE OF DEATH

County Laurance
Township mt vernon
City _____ (No. _____)

Registration District No. 470
Primary Registration District No. 5633

File No. _____
Registered No. 283
St. _____ Ward _____

2. FULL NAME

James H. Mc Donald

(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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

W

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

Married

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

Husband

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

Mar 30, 1865

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

63

19

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

farmer

(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)

Jefferson County Missouri

10. NAME OF FATHER

Joseph M^r Donald

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

Jefferson Co. Mo.

12. MAIDEN NAME OF MOTHER

Sarah Daniel

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

Jefferson Co. Missouri

14.

INFORMANT (Address)

J W Mc Donald, Hobersburg

FILED

June 10 28

19

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

May 19 1928

17.

I HEREBY CERTIFY, That I attended deceased from April 23, 1928 to May 19, 1928 that I last saw him alive on May 13, 1928 and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

cerebral embolism
47B
11B
11B

CONTRIBUTORY (SECONDARY)

Bad teeth & fine infection

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

with 4 years

8 DID AN OPERATION PRECEDE DEATH DATE OF

WAS THERE AN AUTOPSY

WHAT TEST CONFIRMED DIAGNOSIS

(Signed)

C. W. Shelton 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

L.O.O.F. Cem.

5/20 1928

20. UNDERTAKER

ADDRESS

Phillips & Jones mt vernon Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

