AUG 23 1928

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

Do not use this space.

File No. 23573

Registered No. 547

1. PLACE OF DEATH

County: Green — Registration District No. 318

Township: N. Campbell — Primary Registration District No. 5439

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

2. FULL NAME R. H. McCluster

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) R#4 (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: White

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

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Unknown

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Unknown 1838

7. AGE: Years 90 | Months Unknown | Days | If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN): Unknown
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER: Unknown

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

12. MAIDEN NAME OF MOTHER: Unknown

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

14. INFORMANT: Geo Lovort
(Address): Lovort Home

15. FILED 7-28 1928 Oettorst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 7-27 1928

17. I HEREBY CERTIFY, That I attended deceased from July 20, 1928, to July 27, 1928, that I last saw h. alive on July 27, 1928, and that death occurred, on the date stated above, at 6 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Colon Pneumonia

..... (duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (SECONDARY): Senility

..... (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 signs

(Signed) Elias A. Geoby, M. D.

, 19 (Address) 710 Northwest Bldg

*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: Greene Co Farm — DATE OF BURIAL: 7-28 1928

20. UNDERTAKER: N. J. Bradshaw — ADDRESS: Springfield

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.