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

Do not use this space.

File No. 27359
Registered No. 3435

1. PLACE OF DEATH U.S.VET.HOSP.#67,
County Jackson
Township Raw
City Kansas City, Mo. (No. U. S. Veterans Hosp. St. Ward)
Registration District No.
Primary Registration District No.

2. FULL NAME MINTON, George Allen C- 1,229,619
(a) Residence. No. Fortescue, Missouri. St., Ward. Pvt. 1st Cl. 2 M.Corps.
(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: 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: Unknown.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 20, 1893

7. AGE: Years 35 | Months 1 | Days 25 | If LESS than 1 day, ... hrs. or ... min.

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

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

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): Unknown.

14. INFORMANT: Hospital Records,
(Address) U.S.VET.HOSP., Kansas City, Mo.

15. FILED 8/15, 19 28 M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) August 15, 28. 19

17. I HEREBY CERTIFY, That I attended deceased from August 9, 19 28, to August 15, 19 28 that I last saw him alive on August 14, 19 28, and that death occurred, on the date stated above, at 7:25 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Thrombosis Right Femoral.
(duration) yrs. mos. 8 ds.
CONTRIBUTORY (SECONDARY) Cardiac Arrhythmia and Hypertrophy (duration) Unknown. yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? Home.
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? No.
WHAT TEST CONFIRMED DIAGNOSIS? None - Physical examination.
(Signed) W.E. CHAMBERS, M.D.
(Address) Chge. U.S.VET.HOSP., Kansas City, 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Mound City Mo. DATE OF BURIAL: 8/15 19 28
20. UNDERTAKER: The Taylor Funeral Home ADDRESS:

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.

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