

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

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.

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

Do not use this space.

28023

1. PLACE OF DEATH  
 County New Madrid Registration District No. 607  
 Township Parton Primary Registration District No. 5806  
 City Hallsport (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. 17  
 Registered No. 17

2. FULL NAME Edward McCall  
 (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. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF single  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 29-1927  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
1 | 5 | \_\_\_\_\_ | \_\_\_\_\_  
 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) Hallsport  
 (STATE OR COUNTRY) MO  
 10. NAME OF FATHER Hat McCall  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Tiptonville  
 (STATE OR COUNTRY) Tenn  
 12. MAIDEN NAME OF MOTHER Lona Junie Woods  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) Dustin Co Missouri

14. INFORMANT Lona Junie McCall  
 (Address) Hallsport Mo  
 15. FILED Aug 29 1928 \_\_\_\_\_ REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

2  
 16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 29 1928  
 17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, that I last saw him \_\_\_\_\_, \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_, \_\_\_\_\_, Mo.  
 THE CAUSE OF DEATH\* WAS AS FOLLOWS:

measles  
7  
1192 (duration) yrs. mos. da. 8  
 CONTRIBUTORY (SECONDARY) colitis  
 (duration) yrs. mos. da. 10

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?  
 (Signed) C. S. Blackman, M. D.  
Aug 29 1928 (Address) Parma 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 Malden Mo DATE OF BURIAL Aug 30 1928  
 20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

