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

Do not use this space.

739

File No. .....

Registered No. 304

1. PLACE OF DEATH

County: Cole

Township: .....

City: Jefferson City (No. St. Ward)

Registration District No. 213

Primary Registration District No. 5014

2. FULL NAME: St Mary's Hospital Raymond Cleo George

(a) Residence. No. Centertown Ave 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: male

4. COLOR OR RACE: W

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Nov. 2. 1928

7. AGE: Years | Months: 2 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): Centertown

(STATE OR COUNTRY): Mo

PARENTS

10. NAME OF FATHER: John Wm George

11. BIRTHPLACE OF FATHER (CITY OR TOWN): Centertown

(STATE OR COUNTRY): Mo

12. MAIDEN NAME OF MOTHER: Georgia Hearing

13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Jamestown

(STATE OR COUNTRY): Mo

14. INFORMANT: John Wm George

(Address): Centertown Mo

15. FILED 1-2-, 1929 S. W. Bedford, REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Jan. 2. 1929

17. I HEREBY CERTIFY, That I attended deceased from Dec. 24, 1928, to Jan. 2, 1929 that I last saw him alive on Jan 1, 1929 and that death occurred, on the date stated above, at 6:10 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchial pneumonia

122A

107A (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

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

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? yes DATE OF Dec. 24

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

1-2-29, 19 (Signed) S. W. Bedford, M. D.

(Address) J. C. 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: New Hope Cem

DATE OF BURIAL: Jan 2 1929

20. UNDERTAKER: John Williams

ADDRESS: California Mo.

N. B.—Every item of information should be stated, if none, "none," and should be stated in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

1. PLACE OF DEATH.

County: Cole — Registration District No.: 213 — File No.:

Township: — Primary Registration District No.: 304 — Registered No.:

City: Jefferson (No. St. Marys Hosp. St. Ward)

2. FULL NAME: Raymond Leo Gauge

(a) Residence. No. (Usual place of abode) St., Ward (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)
M.	W.	S.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 2 - 1928

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	2	—	

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 1-2, 19 29 S W Bedford REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) JAN 1 1929 19

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchial Pneumonia following an operation (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Strangulated Hernia (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) , 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 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

118 A1

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