

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

Do not use this space.

2201

1. PLACE OF DEATH

County Laclede
Township Engliss
City Hearld (No. 132)

Registration District No. 450
Primary Registration District No. 156/15

File No. 1
Registered No. 1
St. _____ Ward _____

2. FULL NAME

Harold R Magee

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M **4. COLOR OR RACE** W **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word) single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 25-1926

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
2 3- 22

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Child at Home
(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) Laclede Co Mo

10. NAME OF FATHER

Clarence Magee

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER

Alta Shackley

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Mo

14. INFORMANT

Clarence Magee
(Address) Lebanon Lincoln

15. FILED

124 29 Daathins
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 17 1929

17. I HEREBY CERTIFY, That I attended deceased from 1/11/29, 1929, to 1/17/29, 1929, that I last saw him alive on 1/17/29, 1929, and that death occurred, on the date stated above, at _____

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Dysentery acute
130
160
CONTRIBUTORY (SECONDARY) _____
(duration) _____ yrs. _____ mos. _____ da.

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) Ja. M. Coube, M. D.

(Address) 1/18/29 19 Lebanon, 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 Lebanon Cemetery **DATE OF BURIAL** 1-19-29

20. UNDERTAKER Holman Stewart **ADDRESS** Lebanon Mo

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.

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