

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

Do not use this space.

18400
13-7-29
2447

1. PLACE OF DEATH

County Jackson Registration District No. _____
Township Raw Primary Registration District No. _____
City J. C. Mo. (No. 1600 Olive St.) St. _____ Ward) _____

File No. _____
Registered No. _____

2. FULL NAME

Joseph Mc Grin Jr.
(a) Residence No. 1600 Olive St. 11 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 Wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Child

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb-3-1929

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
- 3 24

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none
(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) K. C. Mo.

10. NAME OF FATHER Joseph Mc Grin

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

12. MAIDEN NAME OF MOTHER Rose Gurgan

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

14. INFORMANT Rose Mc Grin
(Address) 1600 Olive St.

15. FILED 5/29/29 M. M. Crowe REGISTRAR
asst.

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 27 1929

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchial pneumonia

107R
89R (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Chile media (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

0 DID AN OPERATION PRECEDE DEATH? No DATE OF _____

10000
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
(Signed) Stanley M. Hall, M. D.

5/27, 1929 (Address) X. 16. 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 Highland Park DATE OF BURIAL May 28 1929

20. UMBERTAKER Mrs. C. L. Forster ADDRESS K. C. Mo.

K. E.—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.

