

SEP 24 1929

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

Do not use this space.

27358

1. PLACE OF DEATH

County Dave
Township Colfax
City Colfax (No. _____) St. _____ Ward _____

Registration District No. 255-
Primary Registration District No. 533E

File No. _____
Registered No. 14

2. FULL NAME

Chas Gurney

(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. 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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 14-1870

7. AGE YEARS MONTHS DAYS 59 | 0 | 18 | — | —
IF LESS than 1 day, — hrs. or — min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Danvers Co., Missouri
(STATE OR COUNTRY)

10. NAME OF FATHER E. Gurney

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

12. MAIDEN NAME OF MOTHER Dont know

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

14. INFORMANT Jane Gurney
(Address) Riederer Mo.

15. FILED 29 1929 D. M. Claggett REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug-1 19 29

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. dead Aug 1, 1929, and that death occurred, on the date stated above, at 4 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic nephritis
131 Heart Disease
95B (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 129A (duration) yrs. mos. ds.

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

18 DID AN OPERATION PRECEDE DEATH: _____ DATE OF _____
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) H. A. Hope Crown
8/2, 1929 (Address) Gallatin, 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 Riederer Cemetery DATE OF BURIAL 8/2 19 29

20. UNDERTAKER A. F. Powell ADDRESS Riederer

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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