MAR 28 1930

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

Do not use this space. 7529 ~~7513~~

1. PLACE OF DEATH
County: Wright
Township: E. Dallas
City: ..... (No. ..... St. ..... Ward)
Registration District No. 898
Primary Registration District No. 6204
File No. .....
Registered No. 7

2. FULL NAME James Henry Mack
(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: m
4. COLOR OR RACE: w
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 1 1849

7. AGE: Years 81; Months 1; Days; If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Miamisburg
(STATE OR COUNTRY) Ohio

PARENTS
10. NAME OF FATHER Thomas Mack
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) ~~[illegible]~~ Ireland
12. MAIDEN NAME OF MOTHER Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Ireland

14. INFORMANT Steve H. Mack
(Address) Fordland, Mo Rt #2

15. FILED 2-2, 1930 John W. Good
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-1-1930

17. I HEREBY CERTIFY, That I attended deceased from 12-1-, 1929, to 1-31-, 1929 that I last saw h. ~~[illegible]~~ alive on 1-31-, 1929, and that death occurred, on the date stated above, at 1:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Cancer of mouth & throat
45C
45F (duration) 5 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? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) S. O. H. Williams, M.D.
2-1-, 1930 (Address) Fordland, 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: Mt Olive
DATE OF BURIAL: 2-2 1930

20. UNDERTAKER: E F Starr
ADDRESS: Fordland

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.