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

Do not use this space. 20805 20803

1. PLACE OF DEATH

County ..... Registration District No. 781

Township ..... Primary Registration District No. 1003 File No. ..... Registered No. 5602.

City St. Louis (No. Mo. City Hospital 2 St. ..... Ward)

2. FULL NAME Geo McGhee

(a) Residence. No. 4324 S. Gamon St., 18 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 17 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)
Male	Col	Widower

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 12-9-1875

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	54	5	25	

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) Lead Factory
(c) Name of employer unknown

9. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY) Ga

PARENTS

10. NAME OF FATHER Foster McGhee

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

12. MAIDEN NAME OF MOTHER unknown

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

14. INFORMANT Gertrude Creath
(Address) City Hospital

15. JUN -9 1930 FILED, 19..... Wm C Hatter REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-4 1930

17. I HEREBY CERTIFY, That I attended deceased from 4-25, 1930, to 6-4, 1930, that I last saw h. alive on 6-4, 1930, and that death occurred, on the date stated above, at 8 30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchopneumonia
1 27
1 07 A
1 25 A (duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (SECONDARY) Operation for enlarged Prostate (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? yes DATE OF 4-29-30 (Supra-pubic Cystotomy)

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) H K Weathers, M.D.

6/6, 1930 (Address) City Hospital

*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 Greenwood Cem. DATE OF BURIAL 6/9 1930

20. UNDERTAKER Peoples Und. Co. ADDRESS 3100 Franklin

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.

THIS IS A PERMANENT RECORD