

WRITE PLAINLY, WITH UNFADING INK—THIS IS A STATE 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.

LOCAL OFFICE  
 OCT 3 1930  
 3 1930

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

Do not use this space.

31942

1. PLACE OF DEATH  
 County Vernon Registration District No. 580  
 Township Chor Creek Primary Registration District No. 61 B F  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_  
 2. FULL NAME James C. McDaniel  
 (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) 11  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
43 10 29  
 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) (STATE OR COUNTRY) Missouri  
 10. NAME OF FATHER G. W. McDaniel  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Missouri  
 12. MAIDEN NAME OF MOTHER Abigail Emmell  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Indiana  
 14. INFORMANT (Address) Mrs. A. E. Biddlecome  
Harwood Mo.  
 15. FILED 9-28-1930 C. B. Davis REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**  
 16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-24-1930  
 17. I HEREBY CERTIFY, That I attended deceased from 9-24-1930 to 9-24-1930, that I last saw him alive on 9-24-1930 and that death occurred, on the date stated above, at \_\_\_\_\_ m.  
 THE CAUSE OF DEATH WAS AS FOLLOWS:  
Cerebral Hemorrhage, "glyphing"  
82 A (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 CONTRIBUTORY (SECONDARY) 7401 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 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? Clinical  
 (Signed) J. W. Dawson, M. D.  
9-26-1930 (Address) 111 North Spry 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 Elber Country DATE OF BURIAL 9-27-1930  
 20. UNDERTAKER Chapman ADDRESS Harwood Mo.

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