

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

Do not use this space.

35360

DEC 29 1930

1. PLACE OF DEATH

County Boone Registration District No. 79 File No. 30
 Township Burbank Primary Registration District No. 4047 Registered No. _____
 City Sturgeon (No. _____) St. _____ Ward _____

2. FULL NAME Geo W. Dagg

(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 W
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 31 - 1862

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
68 | 2 | 29

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Retired
 (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

PARENTS

10. NAME OF FATHER Don't know
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Don't know
 12. MAIDEN NAME OF MOTHER Don't know
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Don't know

14. INFORMANT Family records (Address) _____

15. FILED 12/1/1930 E T Gentry REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-30 1930

17. I HEREBY CERTIFY, That I attended deceased from 11-28, 1930, to 11-30, 1930 that I last saw h. alive on Nov 30, 1930, and that death occurred, on the date stated above, at 9 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Paralytic stroke
8 1/2 hr (duration) about 36 hrs (age)

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED? 7401
 IF NOT AT PLACE OF DEATH _____

8 Did AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? W A Robinson, M. D.
 (Signed) _____, 19 (Address) Sturgeon 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 St. Herb Cemetery DATE OF BURIAL 12-1-1930

20. UNDERTAKER Baron Furniture & Co ADDRESS Sturgeon Mo

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.

