

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

Do not use this space.
Swader Reed
3191 24 Reed
2548
File No. _____
Registered No. 14 _____
St. _____ Ward)

PLACE OF DEATH

County Randolph
Township _____
City Moberly (No. 109 Halleck St)

Registration District No. 735
Primary Registration District No. 3034

2. FULL NAME

Herman Ray Charles McQuary
(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 Negro
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) _____
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 5 - 1931
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
10

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

9. BIRTHPLACE (CITY OR TOWN) Moberly Mo
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER Herman McQuary
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Salisbury
12. MAIDEN NAME OF MOTHER Grace Hazel Carson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Forest Green, Mo

14. INFORMANT Herman McQuary
(Address) 109 Halleck St.

15. FILED 1-15-1931 Dr. J. H. Fleming
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 15 1931
17. I HEREBY CERTIFY, That I attended deceased from Jan-15 1931, to Jan-15-1931, 1931, that I last saw him alive on Jan-15-1931, and that death occurred, on the date stated above, at 6:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho-pneumonia
1070 1070 (duration) yrs. mos. 2 ds.

CONTRIBUTORY (SECONDARY) none
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH at place of death

DID AN OPERATION PRECEDE DEATH? No DATE OF _____
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical symptoms
(Signed) C. H. Swader, M. D.
1-15-1931 (Address) Moberly, Mo.

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Oakland Cemetery
DATE OF BURIAL, Jan 15 1931

20. UNDERTAKER Snow-Heaverton
ADDRESS Moberly, 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.

JAN 20 1931

