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

Do not use this space.

33909

1. PLACE OF DEATH

County: Clay — Registration District No. 198 — File No.

Township: Fishing River — Primary Registration District No. 3011 — Registered No. 126

City: Excelsior Springs, Veterans Hospital — St. 3rd Ward)

2. FULL NAME McCann, George W.

(a) Residence. No. Veterans Hospital, Excelsior Springs, Mo. 4144 Columbia Ave. Des Moines, Iowa
(Usual place of abode) (If not resident given, town or State)

Length of residence in city or town where death occurred yrs. mos. 13 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	white	married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Selma McCann

6. DATE OF BIRTH (MONTH, DAY AND YEAR): February 22 1888

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	43	7	13	

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Kansas

PARENTS

10. NAME OF FATHER: Albert McCann
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ireland
12. MAIDEN NAME OF MOTHER: Frances Sanford
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Canada

14. INFORMANT: Hospital records, Veterans Hosp.
(Address) Excelsior Springs, Mo.

15. FILED Oct 5 1931 — Y. D. Craven, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): October 5 1931

17. I HEREBY CERTIFY, That I attended deceased from Sept. 22, 1931, 19..., to Oct. 5, 1931, 19..., that I last saw him alive on Oct. 5, 1931, 19..., and that death occurred, on the date stated above, at 1:10 a. m. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cirrhosis liver

124B

unknown (duration) yrs. mos. ds.

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

124B

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

0 DID AN OPERATION PRECEDE DEATH? no. DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? exam. & obs.

(Signed) [signature], M. D.

, 19 (Address) Veterans Hospital, Excelsior Springs, 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	DATE OF BURIAL
Joplin, Mo.	10-5-31 19

20. UNDERTAKER: Herbert Hope — ADDRESS: Excelsior Springs 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.

OCT 22 193