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

1. PLACE OF DEATH
County Pemiscot — Registration District No. 656 — File No. 9511-B
Township Cooley — Primary Registration District No. 5873 — Registered No.
City " (No. 2 St. Ward)

2. FULL NAME James Calbert McFall
(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 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

SEP 26 1932

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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Winnie McFall

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 3-9-1881

7. AGE: Years 50 — Months 11 — Days 8 — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Ginner 58
(b) General nature of industry, business, or establishment in which employed (or employer): Burton Gin Co
(c) Name of employer:

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Sturgis Ky 2

PARENTS
10. NAME OF FATHER: Richard McFall
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Virginia
12. MAIDEN NAME OF MOTHER: Martha Cullen
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Ky

14. INFORMANT: Joe McFall
(Address): Blythwille Ark

15. FILED Mar 9 1932 A Harrison REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): March 1st 1932

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 that I last saw h alive on , 19 , and that death occurred, on the date stated above, at 3:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
"Fracture of Skull"
accidentally caught in belt in Cotton Gin (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY): 205 M 2.05 (duration) yrs. mos. ds. 71

18. WHERE WAS DISEASE CONTRACTED (5)
IF NOT AT PLACE OF DEATH ✓
DID AN OPERATION PRECEDE DEATH? ✓ DATE OF ✓
WAS THERE AN AUTOPSY? ✓
WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) James P. Vickrey Carver M. D.
, 19 (Address) Steele 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: Mt Zion Cem — DATE OF BURIAL: 3-2 1932

20. UNDERTAKER: Gennamunch Co — ADDRESS: Steele Mo.

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CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No.....

City..... (No....., ...St. .....Ward)

2. FULL NAME.....

(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	4. COLOR OR RACE	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)

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

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).....
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14.
INFORMANT.....
(Address)

15.
FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17.
I HEREBY CERTIFY, That I attended deceased from.....
....., 19....., to....., 19.....
that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

..... (duration) .....yrs.....mos.....ds.

CONTRIBUTORY.....
(SECONDARY)

..... (duration) .....yrs.....mos.....ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed)..... ....., M. D.

, 19 (Address)

*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 19
20. UNDERTAKER	ADDRESS

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