SEP 14 1934

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

Do not use this space.

29021

1. PLACE OF DEATH.
County Harrison
Township Colfax
City ..... (No. ..... St. ..... Ward)

Registration District No. 335
Primary Registration District No. 3469

File No. 4
Registered No. .....

2. FULL NAME James William McCall.
(a) Residence No. Harrison Co., Mo. St. ..... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 52 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): Married
5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Nancy Jane McCall
6. DATE OF BIRTH (MONTH, DAY AND YEAR): Aug. 20, 1859
7. AGE: Years 74 Months 11 Days 24 If LESS than 1 day, ... hrs. or ..... min.
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): General
(c) Name of employer: Self.
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ohio.

PARENTS
10. NAME OF FATHER: Matthew McCall
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Indiana
12. MAIDEN NAME OF MOTHER: Margaret Bailey
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Unknown.

14. INFORMANT: Mrs. Lillie Smith
(Address): Albany, Mo.

15. FILED 8/15, 1934 R. J. Carter
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Aug 14, 1934

17. I HEREBY CERTIFY, That I attended deceased from Aug 6, 1934, to 8-14, 1934, that I last saw him alive on Aug 14, 1934, and that death occurred, on the date stated above, at 8:15 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
02-A
(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (SECONDARY) P
(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? None
(Signed) W. F. Hoyles, M. D.
8-16, 1934 (Address) Eagleville 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. Pleasant Cem. Harrison Co. Mo.
DATE OF BURIAL: 8/16 1934
20. UNDERTAKER: Robin S. White
ADDRESS: Lamoni, Ia.

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD