

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

Do not use this space.

AUG 9 1939

1. PLACE OF DEATH

County Haddock

Registration District No. 834

Township Becke

Primary Registration District No. 4503

City Advance Mo. (No. 200)

File No. 27011

Registered No. 28

St. _____ Ward _____

2. FULL NAME

Tom McCoy

(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 4 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)

Divorced

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF (OR) ~~WIFE OF~~

Minnie McCoy

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

May 10 1870

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, _____ hrs. or _____ min.

69

1

29

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)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

10. NAME OF FATHER

Liel McCoy

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Mo.

12. MAIDEN NAME OF MOTHER

not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

not known

14.

INFORMANT (Address)

Mrs Paul Byman Advance Mo. 758

15.

FILED

Aug 19 39

D S McKee

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

July 9 1939

17.

I HEREBY CERTIFY, That I attended deceased from May 1 1939 to July 9 1939 that I last saw him alive on May 1 1939 and that death occurred, on the date stated above, at 2:30 A. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Heart Atrophy

(duration) 1 yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY)

Bad mitral lesion

Unknown (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? Clinical

(Signed) E. C. Masters M. D.

. 19 (Address) Advance 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

Crews Cemetery July 9 1939

20. UNDERTAKER

ADDRESS

Lloyd S Morgan Advance Mo

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

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.

RECEIVED

District Health Officer No. 2;

District File Number 839-132

Date Filed 8-7