

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

3011
Do not use this space.

1. PLACE OF DEATH
 (a) County Macon Registration District No. 526
 (b) Township Loda Primary Registration District No. 5700
 (c) City Atlanta (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME U. Grant McQuary 26
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

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 Ollie McQuary

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 27 - 1864

7. AGE YEARS MONTHS DAYS IF LESS THAN 1 day, hrs. or min.
76 6 19

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired Farmer
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Macon, Co., Mo.

FATHER 13. NAME Humphrey McQuary

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Macon Co Mo

MOTHER 15. MAIDEN NAME Eatherine Buster

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

17. INFORMANT (ADDRESS) Ollie McQuary Atlanta, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mt Lober DATE Jan 20 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Humbardding Atlanta Mo

20. FILED Jan 26, 1940 Ruth Mcneely 464 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 17 - 1940

22. I HEREBY CERTIFY That I attended deceased from July 15 1939, to Jan 16 1940
 last seen alive on June 16 1940. Death is said to have occurred on the date stated above, at 9:30 a.m.

The principal cause of death and related causes of importance were as follows:
Chronic interstitial nephritis
History of 4 years albuminuria
Cardiac hypertrophy
Chronic hypocalcaemic parathyroid
with high calcium function July 39

Other contributory causes of importance:
121

Name of operation _____ Date of _____
 What test confirmed diagnosis? Urinary Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____ 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____ (Signed) Eugene P. Hall M.D.
 _____ (Address) Atlanta, 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.

50 M-1-12-38 I X 14023

RECEIVED

District Health Officer No. 10

District File Number 2-40-321

Date Filed FEB 7 1940

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

H. M. Goodding

....., or by

Registered Apprentice No....., working under my personal supervision.

Signed..... H. M. Goodding

Licensed Embalmer No. 1750

P. O. Address Atlanta, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

S-3011