

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

Do not use this space.

1. PLACE OF DEATH

County..... *Shannon*
Township..... *Burch Tree*
City..... (No.) St. Ward)

Registration District No.
Primary Registration District No. *6411*

File No. **33278**

Registered No.

2. FULL NAME *Edward McGehee*

(a) Residence No. St. Ward.
(Usual place of abode)

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Sept 7 1940*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *20 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) *Mo*
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER *Charley McGehee*

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

12. MAIDEN NAME OF MOTHER *Rurie Kelly*

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

14. INFORMANT *Charley McGehee*
(Address) *Burch Tree Mo*

15. FILED *9-10-1940* *Frank Hyde MD*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Sept 7 1940*

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him alive on *Sept 7 1940*, and that death occurred, on the date stated above, at *11:20 p.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Premature birth

CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. ds.
_____ (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *154*
IF NOT AT PLACE OF DEATH, _____

DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) *R. Q. Davis*, M. D.
, 19____ (Address) *Burch Tree 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 *Burch Tree Mo* DATE OF BURIAL *9-8-1940*

20. UNDERTAKER *7411 Wou* ADDRESS _____

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. 5,

District File Number 10401061

Date Filed