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

Do not use this space.

739

21 1929

1. PLACE OF DEATH
County Cole
Registration District No. 213
File No.
Township
Primary Registration District No. 3014
Registered No. 304
City Jefferson City (No. St. Marys Hospital St. Ward)

2. FULL NAME Raymond Cleo George

(a) Residence. No. Centertown Mo 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	MEDICAL CERTIFICATE OF DEATH
3. SEX: Male	16. DATE OF DEATH (month, day and year) Jan 2 1929
4. COLOR OR RACE: W	17. I HEREBY CERTIFY, That I attended deceased from Dec 24, 1928, to Jan 2, 1929
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single	that I last saw him alive on Jan 1, 1929 and that death occurred, on the date stated above, at 6:10 p.m.
5a. If Married, Widowed, or Divorced HUSBAND of (or) WIFE of	THE CAUSE OF DEATH* was as follows: Bronchial Pneumonia
6. DATE OF BIRTH (month, day and year) Nov 2 1928	122A
7. AGE Years — Months 2 months — Days — If LESS than 1 day, ...hrs. or ...min.	107A (duration) yrs. mos. ds.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work	CONTRIBUTORY (SECONDARY)
(b) General nature of industry, business, or establishment in which employed (or employer)	(duration) yrs. mos. ds.
(c) Name of employer	18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
9. BIRTHPLACE (city or town) Centertown (State or country) Mo	Did an operation precede death? Yes Date of Dec 26
10. NAME OF FATHER John Wm George	Was there an autopsy?
11. BIRTHPLACE OF FATHER (city or town) Centertown (State or country) Mo	What test confirmed diagnosis?
12. MAIDEN NAME OF MOTHER Georgia Kearney	(Signed) S W Bedford, M.D. 1-2-29, 19 (Address) J C Mo
13. BIRTHPLACE OF MOTHER (city or town) Jamestown (State or country) 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.
14. INFORMANT John Wm George (Address) Centertown Mo	19. PLACE OF BURIAL, CREMATION, OR REMOVAL New Hope Cem — DATE OF BURIAL Jan 2 1929
15. FILED 1-2-1929 S W Bedford, REGISTRAR	20. UNDERTAKER John Williams — ADDRESS California Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Cole Registration District No. 213 File No.

Township Primary Registration District No. 304 Registered No.

City Jefferson (No. St Marys Hosp. St. Ward)

2. FULL NAME Raymond Leo Gauger

(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)
M.	W.	S.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 2 - 1928

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	—	2	—	

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 1-2, 19 28 L W Bedford
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) JAN 1 1929 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:

Bronchial Pneumonia
Influenza and
Exhaustion
(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (SECONDARY) Strangulated Hernia
(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

SUPPLEMENTARY

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REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW