

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

Do not use this space.

33966

1. PLACE OF DEATH

County St. Genevieve
Township Saline
City St. Genevieve

Registration District No. 783
Primary Registration District No. 6029

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

George W. McDaniel

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

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

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

Bertha Triplett

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

April 6 1880

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>50</u>	<u>6</u>		

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)

St. Genevieve Co Missouri

10. NAME OF FATHER

Jackson W. McDaniel

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

St. Genevieve Co Missouri

12. MAIDEN NAME OF MOTHER

Candace Church

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

St. Genevieve Co Missouri

14. INFORMANT

Mrs. Daniel McDaniel
(Address) Wingston Mo.

15. FILED

10/7 1930 Mrs. H. N. Vaughn REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 6 1930

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at _____.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Shot gun wound in head
suicide
(Verdict of jury)

CONTRIBUTORY (SECONDARY)

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) Geo. C. Basler Coroner
Oct 6 1930 (Address) St. Genevieve Mo.

*State the DISEASE CAUSING DEATH, or if death 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**

St. Genevieve Full Cemetery Oct 7 1930
20. UNDERTAKER John Basler St. Genevieve Mo.
ADDRESS _____

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.

NOV 28 1930

