

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

Do not use this space.

7714

1. PLACE OF DEATH

County Franklin Registration District No. 83 File No. _____
 Township Lebanon Primary Registration District No. 4051 Registered No. _____
 City Faucett Mo. (No. _____) St. _____ Ward _____

2. FULL NAME

George Fields Montgomery
 (a) Residence No. _____ St. _____ Ward _____ (If nonresident, give city or town and State)
 (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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) _____

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 26 1854

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
76 9 19

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Farming
 (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) Platt Co

10. NAME OF FATHER George Wald Montgomery

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

12. MAIDEN NAME OF MOTHER Pollyann Owens

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

14. INFORMANT G. D. Montgomery (Address) St Joseph P. O. 3

15. FILED 9/6 1930 W. S. Hull REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 5 1930

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1930 to March 5 1930 that I last saw him alive on March 5 1930, and that death occurred, on the date stated above, at 4:10 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Myo Carditis
93C
 (duration) 10 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) _____ (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) J. D. Myers M. D.

(Address) St Joseph 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 Agency DATE OF BURIAL March 7 1930

20. UNDERTAKER H. A. Sullivan ADDRESS Gower Mo

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.

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

APR 23 1930

