CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

Do not use this space.

30139

File No. 3947

Registered No.

1. PLACE OF DEATH
County Jackson
Township Kaw
City Kansas City (No. 5319 Lydia St. Ward)

Registration District No. 399 / 4002

Primary Registration District No.

2. FULL NAME David S. McCall

(a) Residence. No. 5319 Lydia 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	MEDICAL CERTIFICATE OF DEATH
3. SEX: M	16. DATE OF DEATH (MONTH, DAY AND YEAR): Sept 26 1930
4. COLOR OR RACE: Wh	17. I HEREBY CERTIFY, That I attended deceased from Aug 27, 1930, to Sept 26, 1930
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widower	that I last saw him alive on 9-26, 1930, and that death occurred, on the date stated above, at 1:25 m.
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Ora McCall	THE CAUSE OF DEATH* WAS AS FOLLOWS: Cardiac Thrombosis
6. DATE OF BIRTH (MONTH, DAY AND YEAR): July 15 1869	1351 / 1355 (duration) yrs. mos. ds.
7. AGE: 61 Years, 2 Months, 11 Days. If LESS than 1 day, hrs. or min.	CONTRIBUTORY (SECONDARY): Super pubic drainage Aug 27 – Sept 26 (duration) yrs. mos. ds.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work: Cafe custodian	18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH
(b) General nature of industry, business, or establishment in which employed (or employer)	DID AN OPERATION PRECEDE DEATH? DATE OF
(c) Name of employer	WAS THERE AN AUTOPSY?
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Scotland	WHAT TEST CONFIRMED DIAGNOSIS?
PARENTS 10. NAME OF FATHER: David McCall	(Signed) James T. Ferguson M. D.
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Scotland	9/27, 1930 (Address) 734 Argyle
12. MAIDEN NAME OF MOTHER: Isabell Reid	*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.
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Scotland	19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Richmond Mo. DATE OF BURIAL: Sept 27 1930
14. INFORMANT: Mrs. Chas E. Murry (Address) 2033 E. 71 St. K.C. Mo.	20. UNDERTAKER: Mrs. C. L. Foster ADDRESS: K.C. Mo.
15. FILED 9/27, 1930 W. M. Crane REGISTRAR asst	

Eagle Vi-9581
West Side Bk bg. Vi-6167
402 Benton Wa-0381

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County Jackson — Registration District No. 399 — File No.
Township Kaw — Primary Registration District No. — Registered No. 3947
City Kc Mo (No. 5319 Lydia St. Ward)

2. FULL NAME David S McHeall

(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.

SUPPLEMENTARY

PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH
3. SEX / 4. COLOR OR RACE / 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)	16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-26-1930
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF	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.
6. DATE OF BIRTH (MONTH, DAY AND YEAR)	THE CAUSE OF DEATH* WAS AS FOLLOWS: Cardiac Thrombosis
7. AGE Years / Months / Days / If LESS than 1 day, ...hrs. or ...min.	(duration) yrs. mos. ds.
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	CONTRIBUTORY (SECONDARY) Supra-pubic drainage 9/30-9/26/30 (duration) yrs. mos. ds.
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)	18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Retention of Urine
PARENTS 10. NAME OF FATHER	DID AN OPERATION PRECEDE DEATH? DATE OF
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)	WAS THERE AN AUTOPSY?
12. MAIDEN NAME OF MOTHER	WHAT TEST CONFIRMED DIAGNOSIS? Am Prostatic Enlargement
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)	(Signed) [illegible] 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.
14. INFORMANT (Address)	19. PLACE OF BURIAL, CREMATION, OR REMOVAL — DATE OF BURIAL 19
15. FILED 9-27, 1930 M M Crowe REGISTRAR	20. UNDERTAKER — 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.

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

1930
30139