

APR 27 1927

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

Do not use this space.

8917

1. PLACE OF DEATH

County Marion

Registration District No. 549

Township Masson

Primary Registration District No. 3029

City Hannibal

(No.)

Levering Hospital

File No.

Registered No. 86

St. Ward)

2. FULL NAME Wm. Northcutt Eales

(a) Residence. No. 2021 Spruce 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

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF (OR) WIFE OF

Sarah Eales

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 10 1839

7. AGE

YEARS 87

MONTHS

3

DAYS

7

IF LESS than 1

day, hrs.

or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Retired

(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)

Kentucky

10. NAME OF FATHER

Geo. Eales

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Kentucky

12. MAIDEN NAME OF MOTHER Margaret Northcutt

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Kentucky

14.

INFORMANT

A.W. Eales

(Address)

2021 Spruce St. Hannibal, Mo.

15.

FILED

3/21/27

C. E. Shute

REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 17 1927

17.

I HEREBY CERTIFY, That I attended deceased from McG

im 6, 1927, to McG 17, 1927

that I last saw h. alive on Mar 17, 1927, and that death occurred, on the date stated above, at 4:55 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1866 Exhaustion
194 B
162

CONTRIBUTORY Fractured Hip

Surgical Neck (duration) Yrs. Mos. 12 Ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH:

8 DID AN OPERATION PRECEDE DEATH: DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS:

(Signed) C. E. Shute, M.D.

, 19 (Address) Hannibal 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

DATE OF BURIAL

St. Paul Hill Cem

3/19 1927

20. UNDERTAKER

ADDRESS

Wm. M. Smith Hannibal

Every name or information should be carefully supplied. Ages should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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