

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

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

Do not use this space.

26517

1. PLACE OF DEATH

County Buchanan Registration District No. 85
 Township St. Joseph Primary Registration District No. 1001
 City St. Joseph (No. 603 North 9th) St. _____ Ward _____

File No. _____
 Registered No. 917
 _____ St. _____ Ward _____

2. FULL NAME

Lewis Harlan Attebery
 (a) Residence. No. 603 North 9th St., _____ Ward. _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 3 yrs. _____ mos. _____ da. How long in U.S., if of foreign birth? yrs. _____ mos. _____ da.

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 Emma Attebery
 (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Febr 8 1879

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>78</u>	<u>6</u>	<u>29</u>	

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) Jacksonville
 (STATE OR COUNTRY) Illinois

10. NAME OF FATHER Lewis Attebery

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Mrs. P. H. Heimbarger
 (Address) 603 North 9th St. St. Joseph

15. FILED SEP 8 1927
John G. Wh REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 7th 1927
17. I HEREBY CERTIFY, That I attended deceased from 1926 to 1927
 that I last saw him alive on Sept 6, 1927, and that death occurred at 5 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral hemorrhage
12 A
16 1/4 hrs
 (duration) _____ yrs. _____ mos. _____ da.

CONTRIBUTORY (SECONDARY) Senility
 (duration) _____ yrs. _____ mos. _____ da.

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? Physical
 (Signed) S. P. Walsh, M. D.
9/8, 1927 (Address) Mercy Hospital

*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 Wellington Kansas **DATE OF BURIAL** Sept. 8 1927

20. UNDERTAKER E. G. Biederfader **ADDRESS** 612 Boy 10th

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.

124 1927

1927

