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

Do not use this space.

37542

1. PLACE OF DEATH

County: Marion — Registration District No. 547 — File No.

Township: Mason — Primary Registration District No. 3029 — Registered No. 319

City: Hannibal (No. ..... St. ..... Ward)

2. FULL NAME Eupemia Douglas

(a) Residence. No. 601 Ault St. Moberly, Mo Ward.
(Usual place of abode) (If not resident 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Female	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 12th 1908

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	18	7	5	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer): no
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Auburn Mo

PARENTS
10. NAME OF FATHER: Elmer
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Moberly Mo
12. MAIDEN NAME OF MOTHER: Burck
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Auburn Mo

14. INFORMANT: Elmer Douglas
(Address) Moberly Mo

15. FILED 12/5 1927 C E Strode REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-5-1927

17. I HEREBY CERTIFY, That I attended deceased from Sep 1927, to Dec 4, 1927, that I last saw ... alive on Dec 4, 1927, and that death occurred, on the date stated above, at 12 10 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Colon Bacillus Infection
123C
114B
(duration) yrs. 4 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? General symptom
(Signed) A L Shanks, 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: Moberly Mo — DATE OF BURIAL: Dec 6th 1927

20. UNDERTAKER: James O'Donnell — ADDRESS: Hannibal

IN 19 1927

19-6-23

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.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Marion — Registration District No. 547 — File No. ...

Township ... — Primary Registration District No. 3029 — Registered No. 319

City Hannibal (No. ..., ... St. ... Ward)

2. FULL NAME Eupemia Douglas

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
F	W	W

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 12. 1808

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ... min.
X	19	6	23	

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

9. BIRTHPLACE (CITY OR TOWN) ...
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ...
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ...
(STATE OR COUNTRY)

14. INFORMANT ...
(Address)

15. FILED 12/5, 1927 C E Strode REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12 - 5 1927

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.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

... (duration) ... 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? ... DATE OF ...
WAS THERE AN AUTOPSY? ...
WHAT TEST CONFIRMED DIAGNOSIS? ...
(Signed) ..., 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE. PRESCRIBED BY LAW

N. B. ... AGE sh... EX ... NS should ... CAU... classified. Exact statement of ... is very important.

S-37542