

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

Do not use this space.

37546

1. PLACE OF DEATH

County Marion
Towship Shelburne
City Hannibal (No. 6)

Registration District No. 547
Primary Registration District No. 2029

File No. _____
Registered No. 335
Ward 6

2. FULL NAME

L. Merylyn Sister
(a) Residence. No. 1925 Broadway St. 6 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. 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 (OR) WIFE OF

Lucy Sister

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 21 - 1904

7. AGE YEARS MONTHS DAYS IF LESS than day, hrs. or min.
23 1 25

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Shoe worker
(b) General nature of industry, business, or establishment in which employed (or employer) International Shoe Co
(c) Name of employer

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

10. NAME OF FATHER William

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

12. MAIDEN NAME OF MOTHER Fattie Hamilton

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

14. INFORMANT Mrs Fattie Sister
(Address) Hannibal, Mo.

15. FILED 12/27 1927 O. Estroff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12 - 10 - 1927

17. I HEREBY CERTIFY, That I attended deceased from Dec 29, 1927, to Dec 10, 1927, that I last saw him alive on Dec 9, 1927, and that death occurred, on the date stated above, at 6:45 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Obstruction of bowels

1218
12-2-13/17 B
(duration) yrs. mos. 2 da.

CONTRIBUTORY (SECONDARY) Appendicitis
(duration) yrs. mos. 10 da.

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH: _____

1 DID AN OPERATION PRECEDE DEATH? Yes DATE OF Dec 1-9

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? General symptoms

(Signed) A. L. Shambaugh, 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 Shelburne Mo DATE OF BURIAL 12 - - 1927

20. UNDERTAKER James McDonnell ADDRESS Hannibal Mo

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

