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

Do not use this space.

37548

1. PLACE OF DEATH

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

Township: ~~Mason~~ — Primary Registration District No.: 3079 — Registered No.: 337

City: Hannibal (No. Dr. Elizabeth Hos St. 16 Ward)

2. FULL NAME: Robert B. Isbister

(a) Residence. No. 329 Magnolia St., 6th Ward. (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 5 mos. 20 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): Married

5A. IF ~~MARRIED~~, ~~WIDOWED~~, OR ~~DIVORCED~~ ~~HUSBAND~~ OF (OR) ~~WIFE~~ OF: Mary M. Isbister

6. DATE OF BIRTH (MONTH, DAY AND YEAR): June 30th - 27

7. AGE: 60 YEARS — MONTHS: 5 — DAYS: 20 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Piano Tuner

(b) General nature of industry, business, or establishment in which employed (or employer): [illegible]

(c) Name of employer:

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

PARENTS

10. NAME OF FATHER: William

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ireland

12. MAIDEN NAME OF MOTHER: Bruce

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Ireland

14. INFORMANT: Robert W. Isbister (Address) Hannibal Mo.

15. FILED: Dec 21 1927 — C. E. Shrote, REGISTRAR

2. MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 12 - 15 - 1927

17. I HEREBY CERTIFY, That I attended deceased from Sept, 1927, to Dec - 15, 1927, that I last saw him alive on Dec 15, 1927, and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Hypostatic Pneumonia

57B

111B

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Carcinoma of Bladder (duration) ..... yrs. 3 mos. ..... ds.

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

0 DID OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) J. A. Farrell, 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: St Mary Cem. Hannibal — DATE OF BURIAL: 19

20. UNDERTAKER: James D. Ronnell — ADDRESS: Hannibal Mo.

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. 337

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

2. FULL NAME Robert B. Isbister

(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)
M	W	M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 30-1867

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	60	5	15	

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 12/21, 1927 C E Strode
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-15 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 AS PRESCRIBED BY LAW

5-37548