

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

Do not use this space.

9787

1. PLACE OF DEATH

County Marion Registration District No. 047
Township Wagon Primary Registration District No. 3029
City Hannibal (No. 1116 Ely St.) St. _____ Ward _____

File No. _____
Registered No. 52 St. _____ Ward _____

2. FULL NAME

Anna Morgan
(a) Residence. No. 1116 Ely St 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single
6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 7 1900
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. 27 11 2
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

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

10. NAME OF FATHER Joseph Morgan
11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) mo

12. MAIDEN NAME OF MOTHER May Hamilton
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) mo

14. INFORMANT John Morgan
(Address) Hannibal mo

15. FILED 3/10 1928 O. E. Stroh
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 9 1928

17. I HEREBY CERTIFY That I attended deceased from 3-8-28 to 3-8-28 1928
that I last saw her alive on 3-8-28, 1928, and that death occurred, on the date stated above, at 1:10 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis

CONTRIBUTORY (SECONDARY) Don't know
Family student (duration) 2 yrs. mos. da.

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? _____

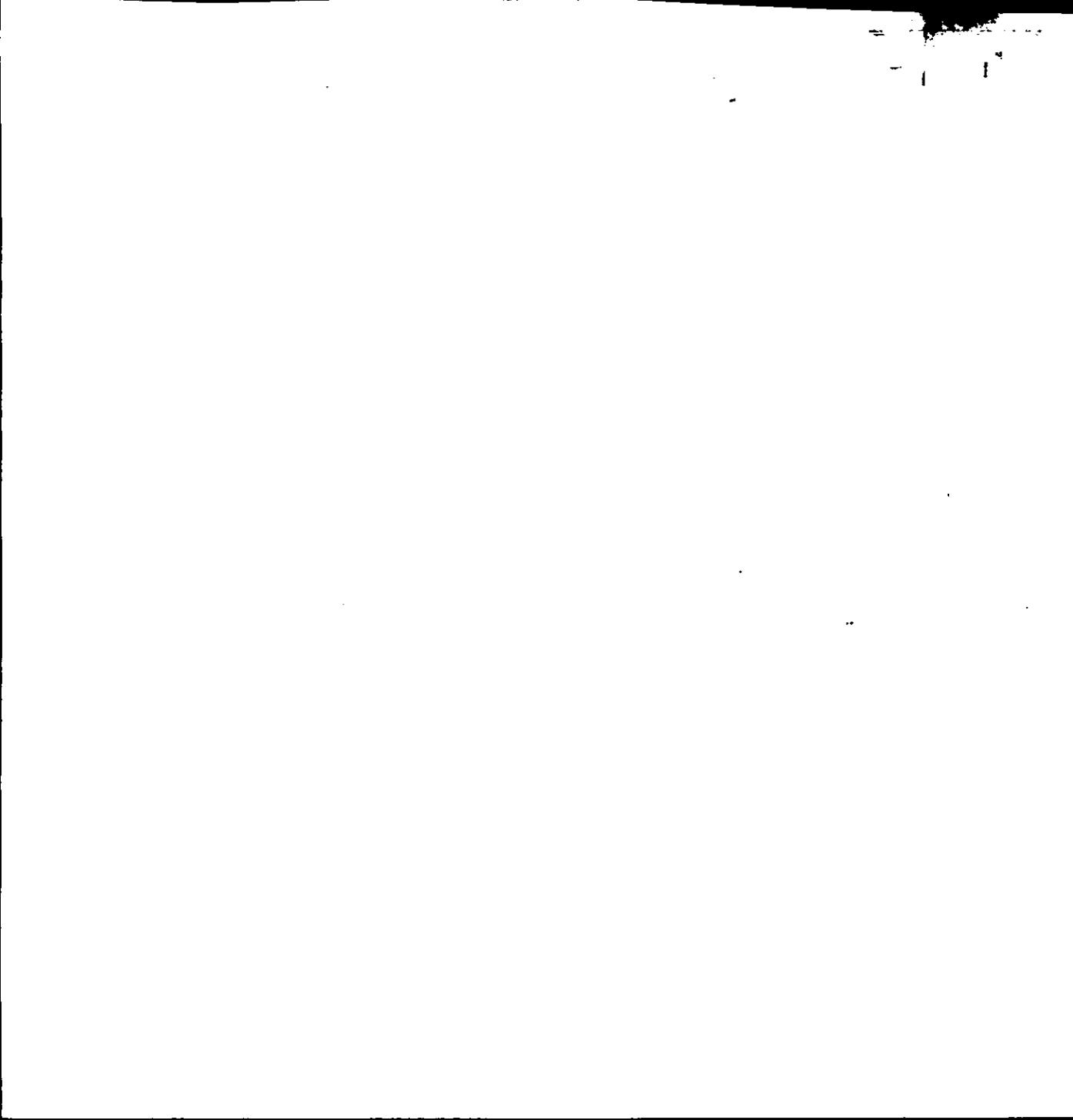
(Signed) W. B. Boney, M. D.

3-10 1928 (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 Mt Olivet DATE OF BURIAL _____
ADDRESS _____

20. UNDERTAKER Wm M Smith ADDRESS Hannibal



**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
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 Hannibal

Primary Registration District No. 3029

Registered No. 52

City Hannibal (No.) St. Ward

2. FULL NAME

Anna Morgan

(a) Residence. No. 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S
(write the word)

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

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

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

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)

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)

INFORMANT (Address)

15. FILED 3/10/28 W.E. Shute REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 9 1928

17. I HEREBY CERTIFY, That I attended deceased from 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

1 3/11 1928

20. UNDERTAKER

ADDRESS

W. M. Smith Hannibal

SUPPLEMENTARY

DO NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED

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