

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

Do not use this space.

1928

14057

1. PLACE OF DEATH

County Marion Registration District No. 547 File No. _____
 Township Mason Primary Registration District No. 3029 Registered No. 93
 City Hannibal (Name of Hospital St. Elizabeth Hospital) St. _____ Ward _____

2. FULL NAME

Worthy A. Leardy
 (a) Residence No. 2619 Broadway 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

MEDICAL CERTIFICATE OF DEATH

3. SEX Female **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word) Married

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 13 1928

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

17. I HEREBY CERTIFY, That I attended deceased from Apr 4, 1928, to Apr 15, 1928, that I last saw her alive on Apr 13, 1928, and that death occurred, on the date stated above, at _____ m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 25 1898

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Peritonitis
12/1/13
12/9
 (duration) _____ yrs. _____ mos. 6 da.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
29 4 18

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

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Housewife
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

18. WHERE WAS DISEASE CONTRACTED 117 B
 IF NOT AT PLACE OF DEATH _____

9. BIRTHPLACE (CITY OR TOWN) St. Louis
 (STATE OR COUNTRY) Mo

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? _____

10. NAME OF FATHER Geo P. Barker

11. BIRTHPLACE OF FATHER (CITY OR TOWN) St. Louis
 (STATE OR COUNTRY) Mo

WHAT TEST CONFIRMED DIAGNOSIS
 (Signed) A. L. DeWitt, M. D.
 , 19 _____ (Address) Hannibal Mo

12. MAIDEN NAME OF MOTHER Eunice Leardy

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) St. Louis
 (STATE OR COUNTRY) 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.

14. INFORMANT Earl E. Leardy
 (Address) Hannibal, Mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St. Louis Mo **DATE OF BURIAL** _____ 19 _____

15. FILED 4/13, 1928 C. E. Stude
 n. m. REGISTRAR

20. UNDERTAKER Wm M Smith **ADDRESS** Hannibal

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
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. 347 File No. _____
 Township _____ Primary Registration District No. 3029 Registered No. 93
 City Jannibal (No. _____) St. _____ Ward _____

2. FULL NAME

Worthy a Cordry
 (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. da. 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 (write the word) m

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

14. INFORMANT _____ (Address) _____

15. FILED 4/13 19 18 66 Shode

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 13 19 28

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:

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 _____

20. UNDERTAKER _____

ADDRESS _____

N. B. ...ry item of information should be stated EX. ... PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

SUPPLEMENTARY

FSOH-8