

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

Do not use this space.

17810 X

File No. _____
Registered No. 172
St. _____ Ward _____

JUL 7 1928

1. PLACE OF DEATH

County Marion
Township Mason
City Hannibal (No. 1909 & Settle St)

Registration District No. 547
Primary Registration District No. 2079

2. FULL NAME

(a) Residence. No. 1909 & Settle St., _____ Ward _____
(Usual place of abode)

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

col

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

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

Wm Washington

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

about 1869

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
<u>about 59</u>	<u>-</u>	<u>-</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Wife
(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)

Palmyra MO

10. NAME OF FATHER

Ed Howard

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

MO

12. MAIDEN NAME OF MOTHER

No record

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

14.

INFORMANT Wm Washington
(Address) 1909 & Settle St

15.

FILED May 9, 1928
W. C. Stone REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 7 1928

17. I HEREBY CERTIFY That I attended deceased from March 27, 1928, to May 7, 1928 that I last saw her alive on May 6, 1928, and that death occurred, on the date stated above, at 30.37 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

11B Sufleazy
11B
(duration) _____ yrs. _____ mos. _____ da.

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? 11B

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

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) St Tompkins, M. D.
5/8/28 (Address) 17170
*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 Palmyra MO **DATE OF BURIAL** 5/9 1928

20. UNDERTAKER Geo E Roberts **ADDRESS** Hannibal

N. B.—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.

