G 27 1928

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

Do not use this space.

File No. 24460

Registered No. 201

1. PLACE OF DEATH

County: Marion — Registration District No.: 547

Township: Mason — Primary Registration District No.: 3029

City: Hannibal (No. 923, Lindell Ave. St. ..... Ward)

2. FULL NAME Doris Lucile Sinclair

(a) Residence. No. 923 Lindell 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)
Female	White	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): July 25-1928

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

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

9. BIRTHPLACE (CITY OR TOWN): Hannibal
(STATE OR COUNTRY): Mo.

PARENTS

10. NAME OF FATHER: Freeman H. Sinclair
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Rolls Co.
(STATE OR COUNTRY): Mo.
12. MAIDEN NAME OF MOTHER: Julia Frith
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Rolla. Co.
(STATE OR COUNTRY): Mo.

14. INFORMANT: Freeman H. Sinclair
(Address) 923 Lindell Ave.

15. FILED: 7/30, 1928 — [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): July 29 1928

17. I HEREBY CERTIFY, That I attended deceased from July 25, 1928, to July 29, 1928 that I last saw h. alive on July 29, 1928 and that death occurred, on the date stated above, at 7:35 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
~~Cerebral~~
Birth injuries — Cerebral
160B
159D
(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (SECONDARY): Congenital defect of skull
(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) [signature], M. D.
, 19 (Address) Hannibal

*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: Riverside Cem.
DATE OF BURIAL: 7/30 1928

20. UNDERTAKER: Wm M. Smith
ADDRESS: Hannibal Mo

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.