T 30 1928

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

Do not use this space.

31069

1. PLACE OF DEATH
County Marion
Township
City C.B.&D. RR (No. Box Car on C.B.&D. RR. St. Ward)
Registration District No. 547
Primary Registration District No. 3029
File No.
Registered No. 240

2. FULL NAME A. Wilson
(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: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Dont Know
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: X X
6. DATE OF BIRTH (MONTH, DAY AND YEAR): About 1875
7. AGE: Years about ~~50~~ To 55; Months; Days; If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Bum.
(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): Unknown

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: Chas. R. Scott
(Address) Hannibal Mo.
15. FILED 9/8, 1928 C E Stroll REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 2 1928
17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw him alive on ....., 19....., and that death occurred, on the date stated above, at 8:30 P m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Indigestion
1186
(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) Chas R Scott Carson M.D
(Address) Mo Co 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 Cem
DATE OF BURIAL: [illegible] 1928
20. UNDERTAKER: Wm M. Smith Vol.
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.

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 ..... — Primary Registration District No. 3029 — Registered No. 240

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

2. FULL NAME A. Wilson

(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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*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)

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 9/88 1928 C E Strode
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 2 1928

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:

Acute Indigestion from Eating a Gorge of Boiled Coffee at Keokuk Ga

..... (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) Chas. R Scott Coroner M.D.

(Address) Marion Co 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	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

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

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