

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

Do not use this space.

1. PLACE OF DEATH

County Howard
Township Glasgow
City Glasgow (No.)

Registration District No. 379
Primary Registration District No. 4223

File No.
Registered No.
St. Ward)

2. FULL NAME

(a) Residence. No. St. Ward.
(Usual place of abode)
Length of residence in city or town where death occurred 59 yrs. mos. da. How long in U.S., if of foreign birth? 59 yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF William Bibbo

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 15 1869

7. AGE. YEARS MONTHS DAYS
59 0 0
If LESS than 1 day, ... hrs. min.

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) Howard County Mo
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER William Heasabel

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Not known
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Burns

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

14. INFORMANT William Bibbo
(Address) Glasgow Mo.

15. FILED 11-17 1928 C.H. Temple
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 15 1928

17. I HEREBY CERTIFY, That I attended deceased from 11 - 11 - 1928, to 11 - 15 - 1928, and that I last saw him alive on 11 - 14 - 1928, and that death occurred, on the date stated above, at 6:30 am

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cancer
139A
129
(duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) Tumor
(duration) yrs. mos. da.

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

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

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) M.B. Retcher, M.D.
11-16, 1928 (Address) Glasgow 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 Lincoln Cemetery DATE OF BURIAL Nov 17 1928

20. UNDERTAKER Tammy Hillen ADDRESS Glasgow 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.

OF DEATH

- Every item of information

should be made known

to the public

**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 Howard
Township Glasgow
City Glasgow (No., St. Ward)

Registration District No. 379
Primary Registration District No. 4223

File No.
Registered No.
St. Ward

2. FULL NAME

(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 Col 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
(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 10, 19 29 C. H. Temple REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 15 - 1928

17. I HEREBY CERTIFY That I attended deceased from 19....., 19..... that I last saw him alive on 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Peritonitis
CONTRIBUTORY (SECONDARY) Tumor growth
Ovarian cyst (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH.....
Did AN OPERATION PRECEDE DEATH?..... DATE.....
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.—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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-36733