

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

Do not use this space.

37159

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Hannibal Primary Registration District No. 1002
 City Hannibal (No. Wheley Hospital)

File No. _____
 Registered No. 4811 St. _____ Ward _____

2. FULL NAME

Mrs. Edna G. Fairfar
 (a) Residence. No. 3507 Tracy St. 13 Ward. _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 7 yrs. 0 mos. 0 ds. How long in U.S., if of foreign birth? 7 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)** Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF BW Fairfar
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 16, 1895
7. AGE YEARS MONTHS DAYS **IF LESS than 1 day, hrs. or min.**
33 10 11 0 0 0

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 _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Morristown, Mo.

10. NAME OF FATHER Robt. M. Madden
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) VA.
12. MAIDEN NAME OF MOTHER Mary Anthony
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Pa.

14. INFORMANT (Address) BW Fairfar
3507 Tracy

15. FILED 11/29, 1928 M. D. Crowe REGISTRAR
over

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 27 19 28
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 _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Accidental automobile
fracture; multiple
injuries

CONTRIBUTORY (SECONDARY) Kansas City, Mo.
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED (IF NOT AT PLACE OF DEATH) 1880

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

WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed) Chas. K. Shofstall, M. D.
11/27, 1928 (Address) Deputy Coroner.

*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 Memorial Park **DATE OF BURIAL** 11/30 19 28

20. UNDERTAKER The Taylor Funeral Home

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

