FEB 22 1929

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

Do not use this space.

✓ X 2463

1. PLACE OF DEATH

County Marion — Registration District No. 547 — File No.

Township ~~Mason~~ — Primary Registration District No. 3029 — Registered No. 23

City Hannibal (No. 21, Meyer Row St. 5 Ward)

2. FULL NAME Melvinian A. Whiteside

(a) Residence. No. 21 Meyer Row St., 5 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)
female	Colored	Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 18 1923

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	5	6	5	

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) Hannibal
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER Arthur Whiteside

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

12. MAIDEN NAME OF MOTHER Katherine Fuqua

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

14. INFORMANT Mrs Melvinia Luckett
(Address) 21 Meyer Row, Hannibal Mo

15. FILED 1/26, 1929 C C Strode
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 23 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 22, 1929, to Jan 22, 1929, that I last saw her alive on Jan 22, 1929, and that death occurred, on the date stated above, at 6 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Kronsko Pneumonia
107A
(duration) yrs. mos. 3 ds.

CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? —
DID AN OPERATION PRECEDE DEATH? No. DATE OF —
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? —

(Signed) A. W. Fox, M. D
, 1929 (Address) Hannibal, 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
Baptist Cemetery	1-27- 1929
20. UNDERTAKER	**ADDRESS**
James O'Donnell	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.