64 mary Ross

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

Do not use this space.

7228

1. PLACE OF DEATH

County Marion — Registration District No. ~~#~~ 547

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

City Hannibal (No. 205 S. Maple St. 5th Ward)

File No.

Registered No. 54

2. FULL NAME Faustina Bruel

(a) Residence. No. 205 S. Maple St., 5th 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: Female
4. COLOR OR RACE: White
5. ~~SINGLE, MARRIED~~, WIDOWED ~~OR DIVORCED (write the word)~~: Widowed

5A. ~~IF MARRIED~~, WIDOWED, ~~OR DIVORCED~~, ~~HUSBAND OF~~ (OR) WIFE OF: Dana Bruel Dec

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Dec. 18th 1847

7. AGE: Years 82 — Months 2 — Days 18 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(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): Canada

PARENTS

10. NAME OF FATHER: John C. Hancock
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): New York
12. MAIDEN NAME OF MOTHER: Mary Pearson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Canada

14. INFORMANT: Mrs. Kate Burch
(Address) Lock Port ~~New~~ York

15. FILED 2/25, 1929 — C. Shoell, REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Feb. 19 1929

17. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19.... that I last saw her alive on ....., 19...., and that death occurred, on the date stated above, at 1:30 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Erysipelas in nose & face generally (duration) yrs. mos. 8 ds.

CONTRIBUTORY (SECONDARY): age & arteriosclerosis doubt. Kno (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? none

(Signed) W. S. Ross, M.D.

Feb. 22, 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: Riverside Cem.
DATE OF BURIAL: Feb. 21 1929

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

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY A[illegible] [illegible]PLI[illegible] [illegible] P[illegible]ESCRIBED BY LAW

1. PLACE OF DEATH.

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

Township — Primary Registration District No. 3029 — Registered No. 34

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

2. FULL NAME Faustina Breed (Surname OK)

(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)
F	W	Wid

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 1 - 1847

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	81	2	1	

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 3/25, 1929 C E Strode
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 19 1929

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:

.....

.....

.....

..... (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) ....., 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 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

S-7228