

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

Do not use this space.

7244

1. PLACE OF DEATH

County Marion Registration District No. 577
Township Mason Primary Registration District No. 3979
City Hannibal St Elizabeth Hospital

File No. _____
Registered No. 576
St. 6 Ward

2. FULL NAME

(a) Residence (Usual place of abode) No. P123 Hope St. 6 Ward. (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

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 Albert Hendricks

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 6 - 1886

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
42 5 17

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) Hannibal Mo
(STATE OR COUNTRY)

10. NAME OF FATHER James Wilkerson

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

12. MAIDEN NAME OF MOTHER Anna Clark

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

14. INFORMANT Albert Hendricks
(Address) 2123 Hope St

15. FILED 17 29 C/O Strode
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from Feb 16, 1929, to Feb 23, 1929
that I last saw h. alive on Feb 23, 1929, and that death occurred, on the date stated above, at 9:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute Cardiac Decompensation
(duration) yrs. mos. da.

CONTRIBUTORY Valvular Disease of Heart
(SECONDARY) (duration) yrs. mos. da.

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) W H Adey, M. D.

, 18 (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 Mt Olivet Cemetery DATE OF BURIAL Feb 26 1929

20. UNDERTAKER Wm M Smith ADDRESS 902 Broadway Hannibal

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.

THIS IS A PERMANENT RECORD

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1

ADP

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Dr Hendricks
First Bldg.

