

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

Do not use this space.

11510

1. PLACE OF DEATH

County Marion
 Township Mason
 City Hannibal

Registration District No. 547
 Primary Registration District No. 3039
 (No. 716 Lindell Ave)

File No. _____
 Registered No. 67
 St. _____ Ward _____

2. FULL NAME

Ida May Dawson

(a) Residence. No. 716 Lindell Ave 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. 4 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

Frank Dawson

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

Jan. 3-1884

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

45

2

8

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)

Spencerburg Mo.

10. NAME OF FATHER

John Howell

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Spencerburg Mo.

12. MAIDEN NAME OF MOTHER

Elizabeth Enlow

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Spencerburg Mo.

PARENTS

14.

INFORMANT (Address)

Mrs. John C. Lloyd
Hannibal Mo.

15.

FILED

3/15/29
E. Stork

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

March 14-1929

17.

I HEREBY CERTIFY That I attended deceased from 15 - 1929 to Mar. 14, 1929

that I last saw her alive on about Mar. 12, 1929, and that death occurred, on the date stated above, at 3:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

diabetes - mellitus

CONTRIBUTORY (SECONDARY)

Carcinoma of cervix

18. WHERE WAS DISEASE CONTRACTED

at home

DID AN OPERATION PRECEDE DEATH? no

DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) E. R. Motley, M. D.

Mar. 12, 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

Mt. Olivet Cemetery

3/13-1929

20. UNDERTAKER

ADDRESS

Schwartz Funeral Home
Hannibal Mo.

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.

1929
 26
 84

235

