

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

Do not use this space.

12284

**1. PLACE OF DEATH**

County.....

Registration District No.....

Township.....

Primary Registration District No.....

City.....

(No. ....)

File No.....

Registered No.....

St.....

Ward.....

**2. FULL NAME**

(a) Residence. No. 4129<sup>a</sup> Chippewa St. 161<sup>b</sup> Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 23<sup>1</sup>/<sub>2</sub> 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)

male | white | widowed

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

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

March 11 - 1848

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, hrs. or min.

80 | 11 | 20

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

Painter

(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)

Indiana

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Unknown

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Unknown

14.

INFORMANT

(Address)

City Hospital  
City Hospital

15.

FILED

19. 1929

Max C. Stanley  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

March 3 1929

17.

I HEREBY CERTIFY That I attended deceased from Jan 22 1929 to March 3 1929 that I last saw him alive on March 3 1929, and last death occurred, on the date stated above, at 17<sup>th</sup> St.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Cerebral Hemorrhage  
Terminal hypostatic pneumonia  
(Congestion of Lung)

CONTRIBUTORY (SECONDARY)

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?

R. Berg  
3/3 1929 (Address) City Hospital, M. D.

\*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

Hannibal Mo.

Mar 7 1929

20. UNDERTAKER

ADDRESS

Roy B. Schwartz

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.

67  
2  
31  
31

Halifax