

28 1929

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

Do not use this space.

15360

1. PLACE OF DEATH

County Marion Registration District No. 547 File No. _____
Township Marion Primary Registration District No. 3027 Registered No. 101
City Hannibal (No. 1) St. Elizabeth Hospital (St. 6 Ward)

2. FULL NAME Elmer B. Stevenson

(a) Residence. No. 1 Kansas City, Mo. 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 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 Ella May

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 28 - 1861

7. AGE Years 68 Months 10 Days 23 If LESS than 1 day, ____ hrs. or ____ min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Minister
(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) Iowa

10. NAME OF FATHER Joe B. Stevenson

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

12. MAIDEN NAME OF MOTHER E. East

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

14. INFORMANT Rev. Mark Stevenson (Address) Chillicothe, Mo.

15. FILED 4/20, 1929 C. E. Slade REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4 - 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:
Broken neck cause by an unavoidable accident in which car was overturned
240M (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED _____ IF NOT AT PLACE OF DEATH: _____

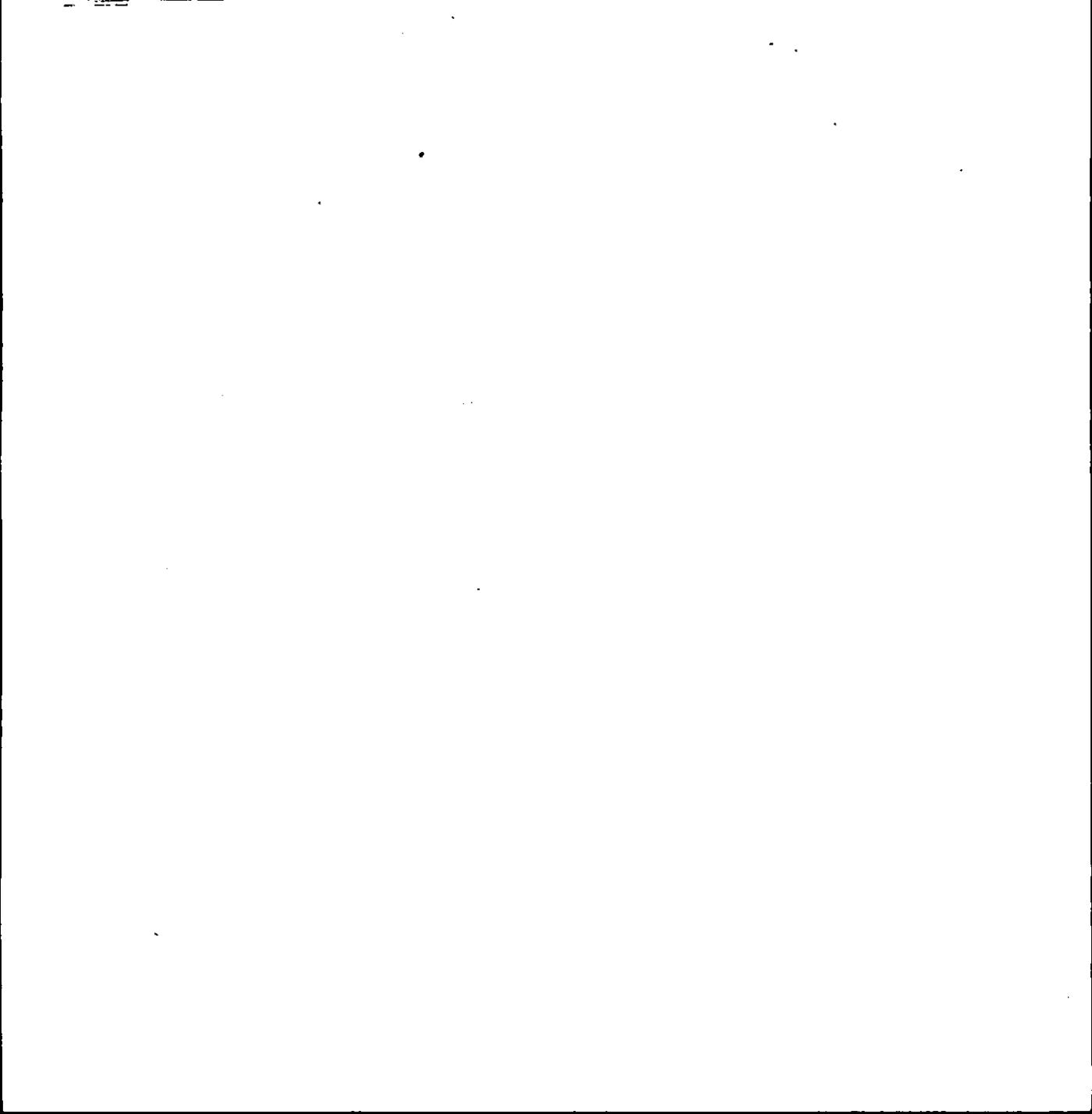
DID AN OPERATION PRECEDE DEATH: _____ DATE OF _____ WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) James O'Donnell Coroner H. D. Marion County (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 Barkville Missouri DATE OF BURIAL 1929

20. UNDERTAKER James O'Donnell ADDRESS Hannibal



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Marion Registration District No. 547 File No. _____
 Township _____ Primary Registration District No. 3029 Registered No. 101
 City Hannibal (No. _____) St. _____ Ward _____

2. FULL NAME

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 28 - 1861

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
67 10 21

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 4/20 1929 C. E. Strode REGISTRAR
m.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7/19 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:

Broken neck caused by unavoidable accident when car was overturned.

(duration) yrs. mos. ds. _____
 CONTRIBUTION James R. - Highway 611
near Hannibal City limits (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

1880 216

1924
15360.