

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

Do not use this space.

X 18783

JUN 27 1929

1. PLACE OF DEATH

County Marion Registration District No. 547
 Township Macey Primary Registration District No. 2029
 City Hannibal (No. 115, Shepherd Place St. Ward)

File No. _____
 Registered No. 138

2. FULL NAME

(a) Residence No. 115 Shepherd Place 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 (use the word) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Wm Ramsey
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 15 1852
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
77 1 13

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) Germany
 (STATE OR COUNTRY)

10. NAME OF FATHER Wm Lachner
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germany
 (STATE OR COUNTRY)
 12. MAIDEN NAME OF MOTHER Cake
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Germany
 (STATE OR COUNTRY)

14. INFORMANT Mrs M. P. Bigger
 (Address) 115 Shepherd Place

15. FILED 6/1 29 REGISTRAR Wm

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 28 1929
 17. I HEREBY CERTIFY, That I attended deceased from April 10 1929, to May 25 1929 that I last saw her alive on May 28 1929, and that death occurred, on the date stated above, at 9.25 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

myocarditis
93D
1671
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) Sensibly
 (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 _____
 (Signed) J. B. Chittam, M. D.
5/30 1929 (Address) Hannibal

*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 Cem. DATE OF BURIAL May 30 1929

20. UNDERTAKER Wm M. Smith ADDRESS Hannibal

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.

28-2
 10-10-10

