

4
1929
An. Goodrich

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

Do not use this space.

+ 22053

1. PLACE OF DEATH

County Mason
Township Mason
City Hannibal (No. Severing Hospital)

Registration District No. 547
Primary Registration District No. 3029

File No. _____
Registered No. 155
St. 6 Ward

2. FULL NAME

(a) Residence No. 3919 London Gravel Rd. St. 5 Ward.
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) don't know

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
About 62

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Williams Constructors, Co.
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Switzerland

PARENTS

10. NAME OF FATHER don't know

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 Mrs. John Bell (Address) Hannibal Mo.

15. FILED 6/19 1929 B. Hurston DEPUTY REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 18 - 1929

17. I HEREBY CERTIFY, That I attended deceased from 6-15-29, 1929, to 6-18-29, 1929, that I last saw h.l.m. alive on 6-18-29, 1929, and that death occurred, on the date stated above, at 2:40:00 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral hemorrhage
1943
82A

CONTRIBUTORY (SECONDARY) Multiple fractures of skull
(duration) yrs. mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

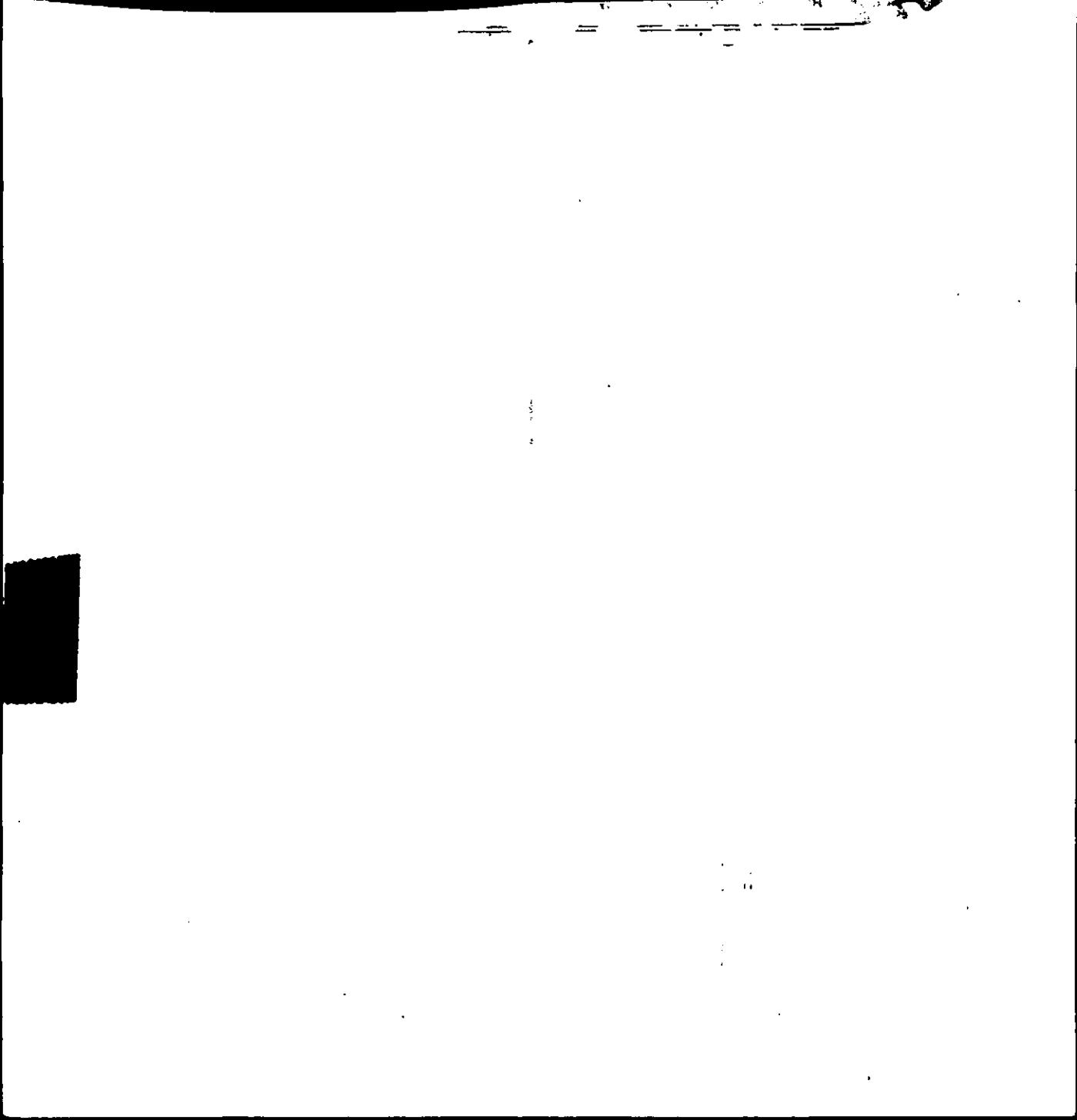
1 DID AN OPERATION PRECEDE DEATH? Yes DATE OF 6-15-29
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Examination
(Signed) Harold B. Frodick, M. D.
6-18-29 (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 6/20-1929

20. UNDERTAKER Schwartz Funeral Home ADDRESS Hannibal Mo.



MISSOURI STATE BOARD OF HEALTH
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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. 15-5-
 City Hannibal (No. _____) St. _____ Ward _____

2. FULL NAME Pete Mullen

(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) W

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

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

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

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) _____

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 6/19/29 D. Austin REGISTRAR
Deputy

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 18 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:
Cerebral hemorrhage from laceration of anterior branch of middle cerebral artery Stone Fall and struck on head - during an excavation for an
Multiple fracture skull due to injury
 CONTRIBUTORY (SECONDARY) _____ (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) Harvey B. Sorduel, M. D.
8-29 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 _____ 19____

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

during an excavation for an

REGISTRARS, 384

1929
22053