

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

Do not use this space.

31346

1. PLACE OF DEATH

County Marion Registration District No. 547
Township Marion Primary Registration District No. 3079
City Hannibal Mo (No. 611 Section St.) St. 1-9 (Ward)

File No. _____
Registered No. 2058
St. 1-9 (Ward)

2. FULL NAME

Jessie Mae Youle
(a) Residence No. 611 Section 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (or) WIFE OF John W. Youle

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 26 - 1872

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
57 3 6

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) Somonauk Ill.
(STATE OR COUNTRY)

10. NAME OF FATHER J. V. Hairy

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Miss Helen Youle
(Address) Hannibal Mo.

15. FILED 9/30/29 Colossius REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 2 19 29

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and that I last saw him/her alive on _____, 19____, and that death occurred, on the date stated above, at about 5 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

By Hanging self in
Room
1/23
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) 168
(duration) _____ yrs. _____ mos. _____ ds.

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

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

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) James P. Donnell
(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 DATE OF BURIAL Sept. 4 19 29

20. UNDERTAKER Wm M. Smith ADDRESS Hannibal Mo.

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.

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8
1929

9235
9
8
81

