

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

Do not use this space.

31364

**1. PLACE OF DEATH**

County Maries Registration District No. 547  
Township Mazon Primary Registration District No. 3079  
City Hannibal (No. St. Elizabeth's Hospital)

File No. 224  
Registered No. 3079  
St. 6 Ward 4

**2. FULL NAME**

(a) Residence. No. 319 North St. 1 Ward. 1  
(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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single  
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 20, 1907  
7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
22 7 2

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Forman in shoe factory  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer International Shoe Co.

9. BIRTHPLACE (CITY OR TOWN) Hannibal  
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER William Frier  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Heckville  
(STATE OR COUNTRY) Mo.  
12. MAIDEN NAME OF MOTHER Elizabeth Becker  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Hannibal  
(STATE OR COUNTRY) Mo.

14. INFORMANT Mrs. William Frier  
(Address) Hannibal, Mo.

15. FILED 9/24 1929 O. E. Cousins  
REGISTRAR

**3 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-23-1929  
17. I HEREBY CERTIFY, That I attended deceased from 9/19 1929 to 9-23-1929 that I last saw him alive on 9-23-1929 and that death occurred, on the date stated above, at 7:30 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
General peritonitis  
131A  
129  
CONTRIBUTORY (SECONDARY) Jaundice (duration) yrs. mos. ds. 6

18. WHERE WAS DISEASE CONTRACTED his home  
IF NOT AT PLACE OF DEATH, DATE OF 9/19-29  
DID AN OPERATION PRECEDE DEATH? yes  
WAS THERE AN AUTOPSY? no  
WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) J. J. Brown M. D.

(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 St. Mary Cemetery DATE OF BURIAL 9-25-1929

20. UNDERTAKER James Danell ADDRESS 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.

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10/25

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