

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

Do not use this space.

34397

1. PLACE OF DEATH

County Marion

Registration District No. 547

Township Mason

Primary Registration District No. 3079

City Hannibal (No. 124)

St. N. Levee St. 6th Ward

File No. _____

Registered No. 266

2. FULL NAME

(a) Residence. No. 124 N. Levee St. _____ Ward. _____

(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 <u>Female</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Single</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>June 5, 1929</u>		
7. AGE YEARS <u>4</u>	MONTHS <u>4</u>	DAYS <u>23</u>
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) Hannibal
(STATE OR COUNTRY) Mo

10. NAME OF FATHER Carl J. Patterson

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

12. MAIDEN NAME OF MOTHER Vivie M. Posidon

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

14. INFORMANT Carl J. Patterson
(Address) Hannibal, Mo

15. FILED 11/3, 1929 C. Cousins
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 28 1929

17. I HEREBY CERTIFY, That I attended deceased from Oct. 15, 1929, to Oct. 28, 1929 that I last saw h. ea alive on Oct. 24, 1929, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Bronchitis acuta

18. WHERE WAS DISEASE CONTRACTED 10.1A

(duration) yrs. 1 mos. _____ ds.

CONTRIBUTORY (SECONDARY) Inanition

(duration) yrs. 1 mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH _____

8 DID AN OPERATION PRECEDE DEATH _____ DATE OF _____

WAS THERE AN AUTOPSY _____

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) W. H. A. Denny, M. D.
Hannibal, Mo (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 10/30 1929

20. UNDERTAKER St. Olaf Cem
James Osbourne 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.

