

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

Do not use this space.

37787

1. PLACE OF DEATH
 County MARION Registration District No. 547
 Township MARION Primary Registration District No. 3079
 City HANNIBAL (No. ST. ELIZABETH HOSPITAL St. C Ward)

2. FULL NAME CARL RUSSELL COTHRON
 (a) Residence. No. 2226 CHESTNUT St., 6 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 MALE **4. COLOR OR RACE** White **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word)

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

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

7. AGE YEARS MONTHS DAYS 5 **IF LESS than 1 day, hrs. or min.**

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Child
 (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 RUSSELL COTHRON
11. BIRTHPLACE OF FATHER (CITY OR TOWN) CLARKVILLE (STATE OR COUNTRY) Mo.
12. MAIDEN NAME OF MOTHER LORENA GAMBELL
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) CLARKVILLE (STATE OR COUNTRY) Mo.

14. INFORMANT Mr. Russell Cothron (Address) Hannibal, Mo.
15. FILED 11-23-29 REGISTRAR

2. MEDICAL CERTIFICATE OF DEATH

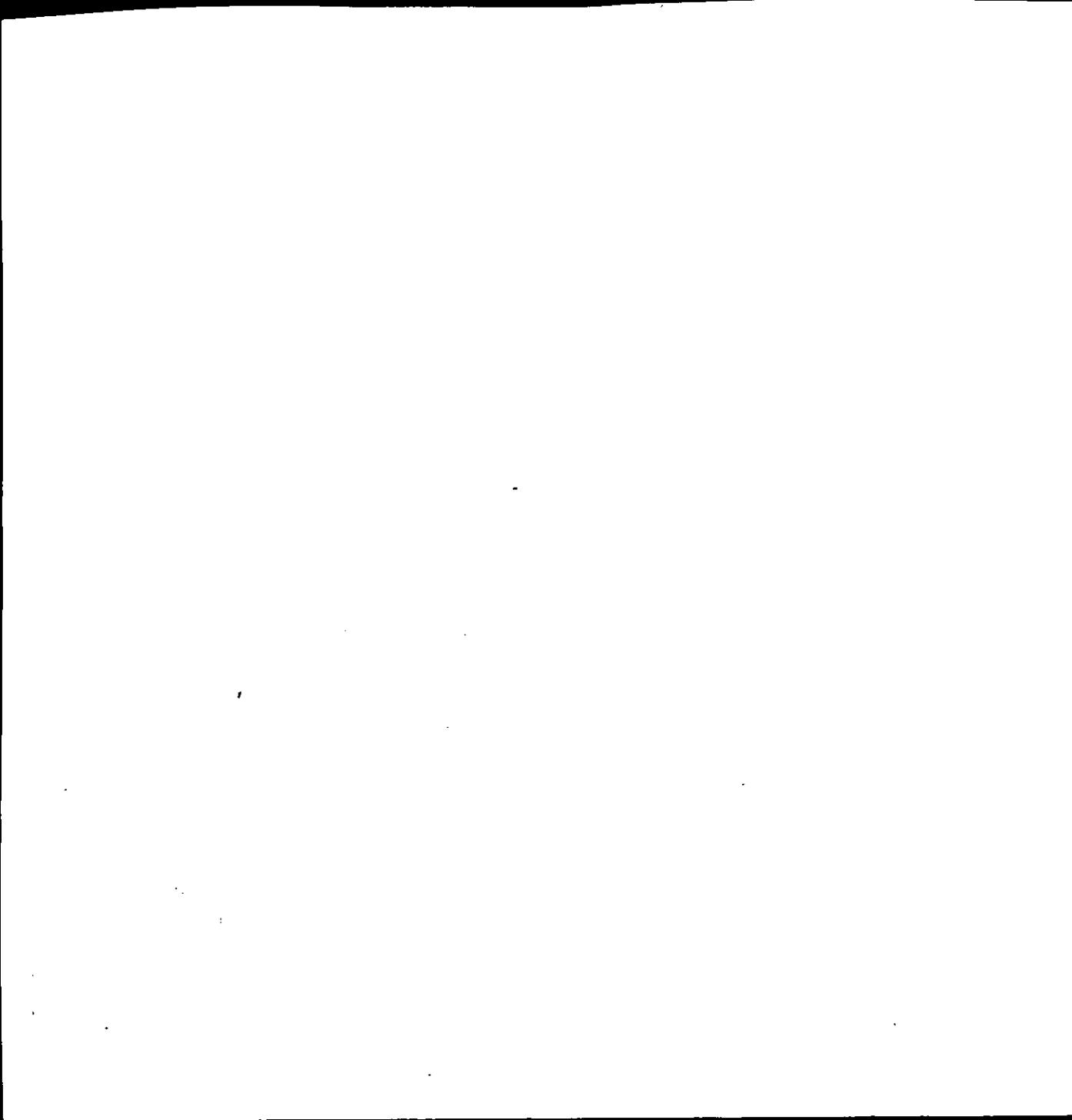
16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-22-1929
17. I HEREBY CERTIFY, That I attended deceased from 11-17, 1929, to 11-22, 1929 that I last saw h. alive on 11-22, 1929 and that death occurred, on the date stated above, at 4:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Congenital defect in wall of sigmoid.
15-15 (duration) yrs. mos. 5 da.
CONTRIBUTORY (SECONDARY) Peritonitis (general) (duration) yrs. mos. 2 da.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH
 DID AN OPERATION PRECEDE DEATH? No. DATE OF
 WAS THERE AN AUTOPSY? Yes - limited to abdomen
 WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
 (Signed) Howard B. Sedwick, M. D.
11-22, 19 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 CLARKVILLE, Mo. **DATE OF BURIAL** 11-23, 1929
20. UNDERTAKER JAMES O'DONNELL **ADDRESS** HANNIBAL, Mo.



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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Marion
Township
City Farmersburg (No.)

Registration District No. 347
Primary Registration District No. 3029

File No.
Registered No. 293
St. Ward)

2. FULL NAME

Carl Russell Othron

(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 (Give the word) A

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 17, 29

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
5

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
(b) General nature of industry, business, or establishment in which employed (or employer) (duration) yrs. mos. ds.
(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 11/22/29 W. Clausius REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 11-22-29

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:

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)....., M. D.

, 19 (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
19

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CE...

SUPPLEMENTARY

5-3-2019