

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

Do not use this space.

41372

PLACE OF DEATH

County Marion Registration District No. 547 File No. _____
 Townshp. St. Elizabeth Primary Registration District No. 2079 Registered No. 306
 City Hannibal (No. St. Elizabeth Hospital) St. 6 Ward)

2. FULL NAME

Rachel Frances Atter
 (a) Residence. No. 2412 Market St., 6 Ward. (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred 6 yrs. mos. da. How long in U. S., if of foreign birth? _____ yrs. mos. da.

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 OF (OR) WIFE OF Marion Atter

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 24 - 1856

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
73 10 9

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) (STATE OR COUNTRY) Baltimore Maryland

10. NAME OF FATHER James W. Coleman

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

12. MAIDEN NAME OF MOTHER Ann Baker

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

14. INFORMANT (Address) Mrs. Emelia West
1171 Estelle Ave St. Louis Mo

15. FILED 17/4 29 Colonusis REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 3 - 1929

17. I HEREBY CERTIFY, That I attended deceased from Nov 30, 1929, to Dec 3, 1929, that I last saw her alive on Nov 30, 1929, and that death occurred, on the date stated above, at 11: P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
93 C
97
Arterio-Sclerosis
Two (duration) _____ yrs. _____ mos. _____ da.
 CONTRIBUTORY Myo-cardial-degeneration (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ da.

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

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Clinical
 (Signed) E. R. Miller M. D.

12/4, 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
Payson Cemetery Payson Ill 12/6 - 1929

20. UNDERTAKER ADDRESS
Schwartz Funeral Home Hannibal

WRITE PAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important.

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