

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

Do not use this space.

41390

1. PLACE OF DEATH

County Marion Registration District No. 547
 Township Marion Primary Registration District No. 302904
 City Hannibal (No. 2212 Spruce St) St. _____ Ward _____

File No. _____
 Registered No. 319
 St. _____ Ward _____

2. FULL NAME Chas Infant

(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 <u>Male</u>	4. COLOR OR RACE <u>Col</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Mary Infant</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>11-25--1924</u>		
7. AGE	YEARS <u>65</u>	MONTHS <u>0</u>
	DAY <u>28</u>	If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer) no
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) MO
 (STATE OR COUNTRY)

PARENTS	10. NAME OF FATHER <u>Henry Infant</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>MO</u>
	12. MAIDEN NAME OF MOTHER <u>No record</u>
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) _____	

14. INFORMANT Mrs Mary Infant
 (Address) 2212 Spruce St

15. FILED Dec 27 19 19 Clousier
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12th 23 1929
 17. I HEREBY CERTIFY, That I attended deceased from 9 P.M.
 _____ 1929
 (that I last saw h. _____ alive on Dec 23 1929 and that death occurred, on the date stated above, at 9 P.M.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Myocarditis
75 D
 (duration) General yrs. mos. ds.
 CONTRIBUTORY General Anasarca
 (SECONDARY) (duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? NO DATE OF _____
 WAS THERE AN AUTO? NO
 WHAT TEST CONFIRMED DIAGNOSIS _____
 (Signed) A. W. Fox M. D.
Dec 26 1929 (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 <u>Robinson Cem</u>	DATE OF BURIAL <u>12/26</u> 19 <u>29</u>
20. UNDERTAKER <u>Geo E Robert</u>	ADDRESS <u>Hannibal</u>

All 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.

THIS IS A PERMANENT RECORD

cash paid to 1777

1777

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Marion
Township.....
City Hannibal (No.)

Registration District No. 547
Primary Registration District No. 3029

File No.
Registered No. 319
St. Ward)

2. FULL NAME

Chas. Dant
(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 Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 11-25-1864

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
65 - 28

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)
(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. Dec 27 29 C.E. Causey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12/23/29

17. I HEREBY CERTIFY, That I attended deceased from to 19..... that I last saw h..... alive on 19..... and that death occurred, on the date stated above, at.....

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

No. B. 1. 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

5-4-80