

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

Do not use this space.

7700

**1. PLACE OF DEATH**

County Boone  
Township Columbia  
City Columbia Mo (No. ....)

Registration District No. 73  
Primary Registration District No. 30.06

File No. ....  
Registered No. 59  
St. .... Ward)

**2. FULL NAME** Ed Ebberson

(a) Residence. No. 204 1/2 South Second 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. .... moa. .... ds. How long in U. S., if of foreign birth? yrs. .... moa. .... ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Within 1890

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. .... min.  
40 None None None

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work. Day Laborer  
(b) General nature of industry, business, or establishment in which employed (or employer). Red Carrier  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Columbia Mo.  
(STATE OR COUNTRY) Boone Mo

10. NAME OF FATHER Ed Ebberson

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

12. MAIDEN NAME OF MOTHER Sarah Pearson

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

14. INFORMANT Mrs Mary Ebberson  
(Address) 204 S - 2nd St - Columbia

15. FILED 4-1-30 Bertrice Gibbs REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-28-1930

17. I HEREBY CERTIFY, That I attended deceased from March 28, 1930, to X, 1930, that I last saw h. .... alive on 7-00 a.m., 1930, and that death occurred, on the date stated above, at 7-00 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Hemorrhage of lungs

CONTRIBUTORY (SECONDARY) Influenza & injury of 2 years (duration) .... yrs. .... mos. .... ds.

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

DID AN OPERATION PRECEDE DEATH? No DATE OF X  
WAS THERE AN AUTOPSY? No

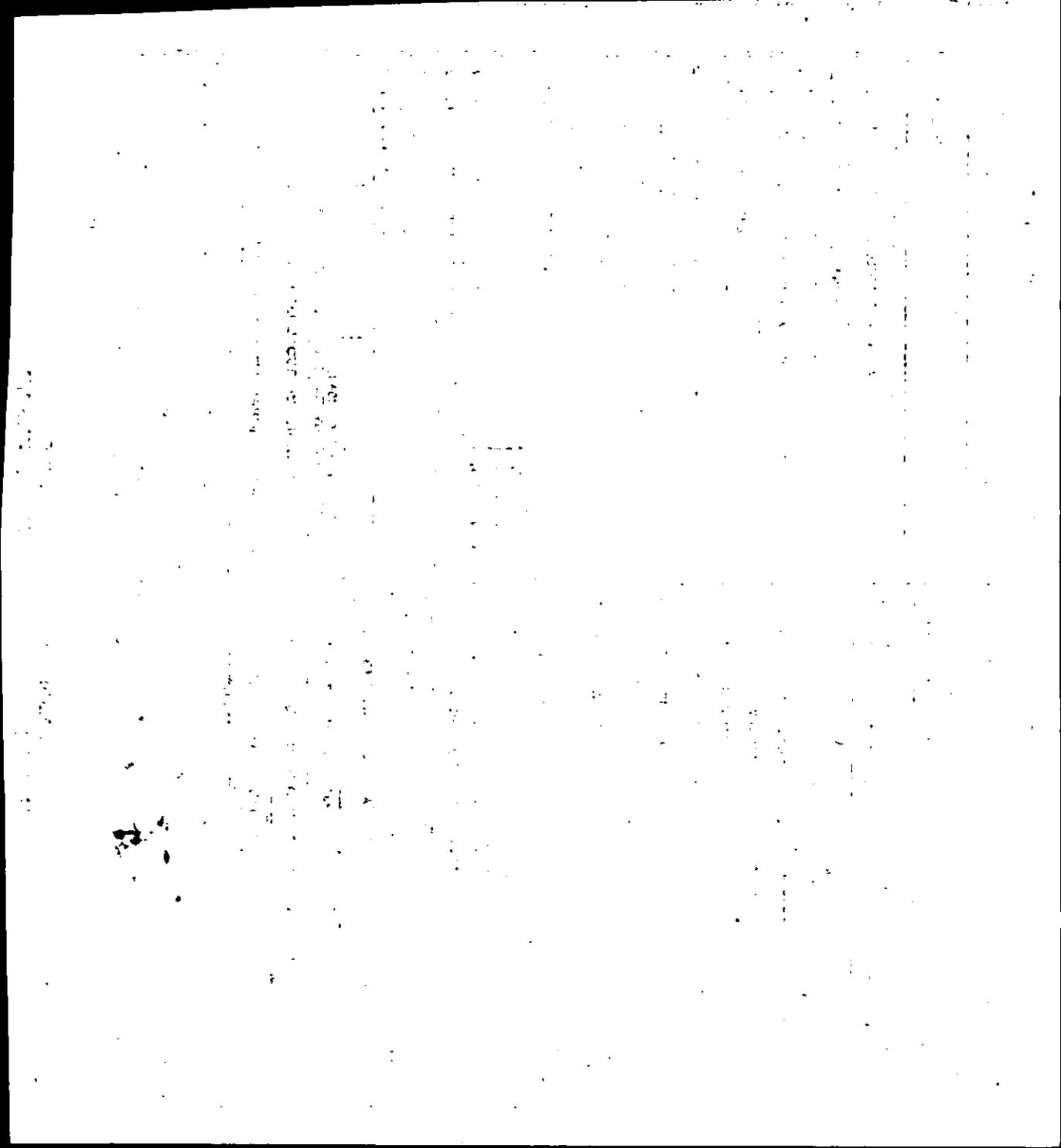
WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) W. L. Davis, Coroner, M. D.  
3-28-1930 (Address) Columbia Mo.

\*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 Columbia Cemetery DATE OF BURIAL 4-1-1930

20. UNDERTAKER Stuart F. Parker ADDRESS Columbia, Mo.

GROSS OF DEATH IN plain terms, so that it may be properly understood.



**MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH**

FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

1. PLACE OF DEATH. *Boone* County Registration District No. *73* File No. \_\_\_\_\_  
*Columbia* Township Primary Registration District No. *3006* Registered No. *58*  
 City (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME *Ed Epperson*

(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**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX *M* 4. COLOR OR RACE *Col* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *M*

16. DATE OF DEATH (MONTH, DAY AND YEAR) *3/28* 19 *30*

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

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*Hemorrhage of lungs*

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 \_\_\_\_\_

CONTRIBUTORY (SECONDARY) *Influenza & injury of 2 years standing from slipping material falling on head & chest*

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_ (STATE OR COUNTRY)

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

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.

\_\_\_\_\_, 19 \_\_\_\_\_ (Address)

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)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

15. FILED *May 27, 30 Beatrice Greaves* REGISTRAR

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION as prescribed by LAW

SUPPLEMENTARY

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