

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.

APR 30 1930

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

Do not use this space.

9505

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1. PLACE OF DEATH

County Marion Registration District No. 547
Township Marion Primary Registration District No. 329
City City (No. 1734) Fulton Ave St. _____ Ward)

File No. _____
Registered No. _____

2. FULL NAME Georgia Mae Pabel

(a) Residence No. 1734 Fulton Ave. 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>March 10-1930</u>		
7. AGE	YEARS	MONTHS
		5
	IF LESS than 1 day, _____ hrs. or _____ min.	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant.

(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) Marion Co. Mo.

10. NAME OF FATHER George Wm Pabel

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

12. MAIDEN NAME OF MOTHER Rubie Taylor

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

14. INFORMANT Idea Wm Pabel
(Address) 1734 Fulton Ave.

15. FILED 3-15-30 W. C. Cousins REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 15 1930

17. I HEREBY CERTIFY, That I attended deceased from March 16 1930 to March 15 1930 that I last saw h. alive on March 15 1930, and that death occurred, on the date stated above, at 1:45 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Congenital deformity of the bile duct

157D (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 159C (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) John Reilly, D.O.

3/15/30 (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 Antioch DATE OF BURIAL Mar 16 1930

20. UNDERTAKER Wm M Smith ADDRESS 902 Broadway Hannibal, Mo

