

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

Do not use this space.

13333

MAY 27 1930

1. PLACE OF DEATH

County Marion
Township Masson
City Hannibal

Registration District No. 547
Primary Registration District No. 3079
(No. 514 Pleasant)

File No. ~~87~~
Registered No. 99
St. 1 Ward

2. FULL NAME

Ellen Maria Liller, (Liller)
(a) Residence. No. 514 Pleasant St., Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF George Liller
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 6 - 1850
7. AGE YEARS MONTHS DAYS IT LESS than 1 day, hrs. or min.
79 7 7
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) Hannibal Mo.

PARENTS

10. NAME OF FATHER Thomas Woods

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

12. MAIDEN NAME OF MOTHER Minerva Kaydon

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

14.

INFORMANT Mrs. Amanda Woods
(Address) Hannibal Mo.

15.

FILED 4/15 1930 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 13 - 1930

17. I HEREBY CERTIFY, That I attended deceased from 4-13, 1930, to 4-13, 1930

that I last saw him alive on _____, 19____, and that death occurred, on the date stated above, at 9:15:17 m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Parent was dead when I arrived at the home.
(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) W. S. Salzen M. D.
, 19 (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

Barkley Cemetery 4-15-1930

20. UNDERTAKER ADDRESS

Schwartz Funeral Home Hannibal

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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