

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

Do not use this space.

20037

1. PLACE OF DEATH

County Marion
Towship Mason
City Hannibal

Registration District No. 547
Primary Registration District No. 3077
No. 600 Butler St

File No. _____
Registered No. H 166
St. _____ Ward) _____

2. FULL NAME

Mary Bell
(a) Residence. No. 600 Butler St., _____ Ward. _____
(Usual place of abode)

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE W.C. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 12-6-1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
70 6 12

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic Wife
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Paris Mo
(STATE OR COUNTRY)

10. NAME OF FATHER Louis Kipper

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

12. MAIDEN NAME OF MOTHER Fannie Tolbert

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

14. INFORMANT Mrs. Gertrude Fropkes
(Address) 600 Butler

15. John D. Co. Cousins
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6-18 19 30

17. I HEREBY CERTIFY, That I attended deceased from 8:40 a.m.
3-16 1930, to June 18 1930
that I last saw her... alive on June 18 1930, and that death occurred, on the date stated above, at 8:40 A.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

93 D.
Nephritis 1930

CONTRIBUTORY (SECONDARY) Myocarditis
(duration) _____ yrs. _____ mos. _____ ds.

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

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) A. W. Fox, M. D.
, 19 30 (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 Baptist Cem DATE OF BURIAL 6/22 19 30

20. UNDERTAKER Geo E Roberts ADDRESS 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.

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23 1930

