

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.

OCT 30 1930

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

Do not use this space.

30515-5

1. PLACE OF DEATH

County Marion Registration District No. 547
Township Marion Primary Registration District No. 3039
City Hannibal (No.) Revering Hospital St. 4th Ward

File No.
Registered No. 256

2. FULL NAME William Donald Heath

(a) Residence. No. 1312 Fulton Ave 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>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>Sept 18, 1930</u>		
7. AGE YEARS	MONTHS	DAYS
		6
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) Missouri

10. NAME OF FATHER Wm C. Heath

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Not known
(STATE OR COUNTRY) Kansas

12. MAIDEN NAME OF MOTHER Virginia Galloway

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

14. INFORMANT Mrs Wm C Heath
(Address) 1312 Fulton Ave Hannibal, Mo.

15. FILED 9/27 30 1930 C. J. [Signature]
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 26 1930

17. I HEREBY CERTIFY, That I attended deceased from Sept 18 to Sept 30, 1930, and that I last saw h. live on Sept 26, 1930, and that death occurred, on the date stated above, at 9:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Congenital atresia of oesophagus

15 9/21
15 8 (duration) yrs. mos. 8 ds.

CONTRIBUTORY Inanition
(SECONDARY) (duration) yrs. mos. 8 ds.

18. WHEN WAS DISEASE CONTRACTED 15 9/21
IF NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? No DATE OF

20. WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS? X-ray & autopsy
(Signed) Harold B. Seaduck M. D.
9-26 1930 (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 Mt. Olivet DATE OF BURIAL Sept 26, 1930

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

