

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.

DEC 2 1930

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

Do not use this space.

33525^a

1. PLACE OF DEATH

County Marion Registration District No. 547
 Township Wason Primary Registration District No. 3079
 City Hannibal (No. 1925 Market) St. 670 Ward

File No. _____
 Registered No. 770
 St. 670 Ward

2. FULL NAME

(a) Residence. No. 1925 Market 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 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 Genevieve Payne

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 8-18-1860

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
70 2 13

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 _____

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

PARENTS
 10. NAME OF FATHER _____
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Wm Payne (STATE OR COUNTRY) Mo
 12. MAIDEN NAME OF MOTHER Mrs Bevera
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

14. INFORMANT Mrs Genevieve Payne (Address) 1925 Market St

15. FILED 11/3, 1930 C. C. Louvain REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10/31 1930

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h _____ alive on _____, 19____, and that death occurred, on the date stated above, at 5:29 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Senility
16 7/2 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) 16 7/2 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) James O'Donnell Cover 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 Baptist Church DATE OF BURIAL 11/3 1930

20. UNDERTAKER Geo & Roberts ADDRESS Hannibal

