

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

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

Do not use this space.

36788

1. PLACE OF DEATH

County Marion Registration District No. 574
Township Massou Primary Registration District No. 309
City Hannibal (No. 1222) Hill St. _____ Ward _____

File No. _____
Registered No. 301
St. _____ Ward _____

2. FULL NAME Fielder Mc Gregor Deyoe

(a) Residence No. 1222 Hill 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 white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) October 14, 1909

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
21 - 27

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) Ponchartraine
(STATE OR COUNTRY) Illinois

10. NAME OF FATHER J Robert Deyoe

11. BIRTHPLACE OF FATHER (CITY OR TOWN) not known
(STATE OR COUNTRY) Ralls Co. Mo.

12. MAIDEN NAME OF MOTHER Marye Fielder

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Pleasant Hill
(STATE OR COUNTRY) Illinois

14. INFORMANT J Robert Deyoe
(Address) Hannibal, Mo.

15. FILED 11/15 30 Clousier
REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) November 11 1930

17. I HEREBY CERTIFY, That I attended deceased from Nov 10 1930 to Nov 11 1930, and that I last saw him alive on Nov 11, 1930, and that death occurred, on the date stated above, at 3:00 P. m.

18. THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic nephritis & hypertension

19. (duration) 2 yrs. mos. ds.
CONTRIBUTORY uremia
(SECONDARY) (duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED? At Home
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Blood Pressure, Urinalysis, etc.
(Signed) Howard B. Goodrich, M. D.

11-11-30 (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 Mt Olivet DATE OF BURIAL Nov 13 1930

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

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.

