

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

38662

JAN 19 1930

1. PLACE OF DEATH

County Buchanan Registration District No. 85
Township _____ Primary Registration District No. 1001
City St. Joseph, (No. 418 North 24th.) St. _____ Ward _____

File No. _____
Registered No. 1310

2. FULL NAME Frank M. Hanna

(a) Residence No. 418 North 24th. St. _____ Ward _____
(Usual place of abode)
Length of residence in city or town where death occurred 52 yrs. 11 mos. 25 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married,

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ida O. Hanna,

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 12, 1877

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
52 11 25

8. OCCUPATION OF DECEASED Agent
(a) Trade, profession, or particular kind of work. Loans & Insurance
(b) General nature of industry, business, or establishment in which employed (or employer).
(c) Name of employer Mumford & Hanna Inv. Co

9. BIRTHPLACE (CITY OR TOWN) Saint Joseph,
(STATE OR COUNTRY) Missouri,

10. NAME OF FATHER Finley Hanna,

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

12. MAIDEN NAME OF MOTHER Mary Woods,

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Unknown,
(STATE OR COUNTRY) Indiana,

14. INFORMANT Mrs. F. M. Hanna
(Address) 418 North 24th Street

15. FILED 8 1930 John G. Up
REGISTERAR

1. MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec. 7, 1930

I HEREBY CERTIFY, That I attended deceased from June 15, 1930 to Dec 7, 1930 that I last saw him alive on Dec 7, 1930, and that death occurred, on the date stated above, at 7:05 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Cerebral vascular (Glissia)

530 (duration) yrs. 5 mos. 20 ds.

CONTRIBUTORY (SECONDARY) None (duration) yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? Yes DATE OF About Aug. 17, 30

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Cerebral Vascular & Glissia
(Signed) _____ M. D.
Dec 8, 1930 (Address) St. Joseph, Mo

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mount Nora Cemetery DATE OF BURIAL Dec. 9, 1930

20. UNDERTAKER Wheaton - Biddle & Bowman ADDRESS 319 S. 10 St.

Funeral Home

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

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County..... Registration District No. 85 File No.
 Township St Joseph Primary Registration District No. 1001 Registered No. 1310
 City (No.) St. Ward

2. FULL NAME

(a) Residence. No. 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M.

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

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) (STATE OR COUNTRY)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address)

15. FILED 1/31 1931 John J. W. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 7 - 19 30

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 m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Central tumor (Carcinoma)
No trace removed at operation
to tumor was due to these -
probably malignant -
 CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) Clarence A. ... M. D.

1/30, 1931 (Address) St Joseph 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

20. UNDERTAKER ADDRESS

N. B.—Every item of information should be as fully 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

29925-5