

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

Do not use this space.

40079

1. PLACE OF DEATH

County Marion
Township Mason
City Hannibal (No. 500)

Registration District No. 547
Primary Registration District No. 329

File No. _____
Registered No. 311
St. _____ Ward _____

2. FULL NAME

Ralph Edgar
(a) Residence No. 500 Union 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

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

Marion Edgar

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

June 3-1886

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
44	5	29	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer Bushington

9. BIRTHPLACE (CITY OR TOWN)

Lenther

(STATE OR COUNTRY) Missouri

10. NAME OF FATHER

Chas. Edgar

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Not known

(STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER

Louisa Leggett

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Memphis

(STATE OR COUNTRY) Tennessee

14.

INFORMANT Mrs. Marion Edgar
(Address) 500 Union St. Hannibal, Mo.

15.

FILED Dec 3, 1930 C. Cousins
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) December 2 1930

17. I HEREBY CERTIFY, That I attended deceased from Nov 10 - 1930 to Dec 2 - 1930, 1930 that I last saw him alive on Dec 2 - 1930, and that death occurred, on the date stated above, at 1:00 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma of stomach
& metastases to liver
46B
46B (duration) 11 yrs. 7 mos. - ds.
CONTRIBUTORY (SECONDARY) 44 (duration) 11 yrs. 7 mos. - ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? Yes DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) [Signature] M. D.

(Address) C. B. Orr - Hannibal

*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

Brookfield, Mo.

DATE OF BURIAL

Dec. 4, 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.

Dec 20 1930



OCT 19 1953