

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

Do not use this space.

2076

1. PLACE OF DEATH

County Marion
Township Mason
City Hannibal (No.)

Registration District No. 547
Primary Registration District No. 3079

File No.
Registered No. 121
Ward 64

2. FULL NAME

Araminta E. Cowan

(a) Residence No. 119 Glasgow St., 54 Ward.

(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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Fred W. Cowan

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 19 - 1868

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
62 0 23

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Tailress 92
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Farmington
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Wm H. Perkins

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

12. MAIDEN NAME OF MOTHER Josephine Burnett

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) not known
(STATE OR COUNTRY) not known

14. INFORMANT Mable Kane
(Address) 119 Glasgow St. Hannibal, Mo

15. FILED 1/13 1931 A. Louise
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) January 12 1931

17. I HEREBY CERTIFY, That I attended deceased from Dec 21, 1930, to Jan 12, 1931, that I last saw h. w. alive on Jan 12, 1930, and that death occurred, on the date stated above, at 5:05 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

tetanus
27
1945
36A Compound fracture (duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) of leg. Bright's Disease (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH

0 DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS General Examinations
(Signed) A. L. Shaul, 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.

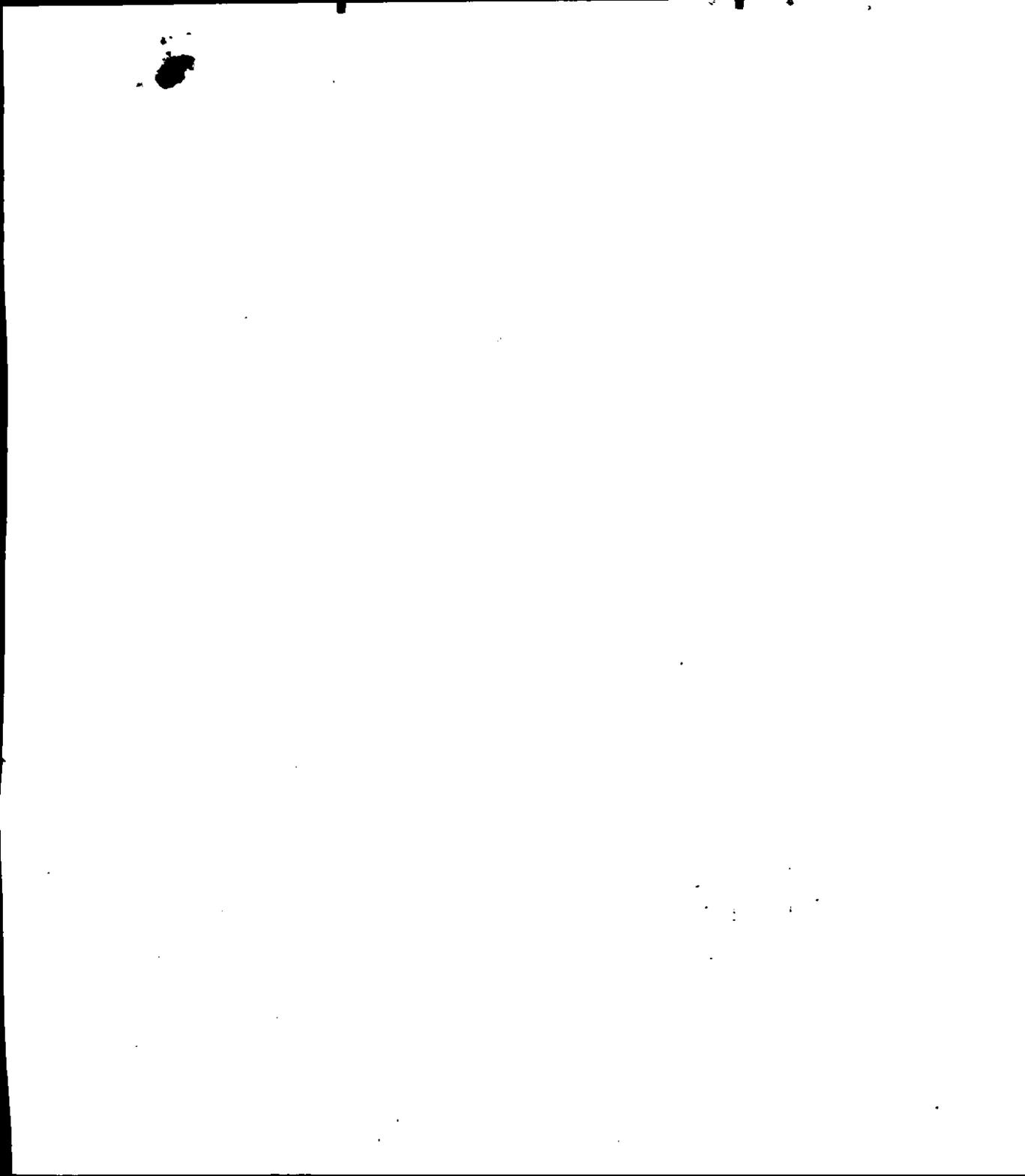
19. PLACE OF BURIAL, CREMATION, OR REMOVAL Independence, Mo. DATE OF BURIAL Jan. 15 1931

20. UNDERTAKER New 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, if very important.

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

1931
64
1



**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 Marion
Township _____
City Hannibal (No. _____)

Registration District No. 547
Primary Registration District No. 29

File No. _____
Registered No. 12
St. _____ Ward _____

2. FULL NAME

Araminta E. Cowan
(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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid

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 3/9/31 6 Cousins REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan, 2 1931

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

THE CAUSE OF DEATH WAS AS FOLLOWS:

Tuberculosis
(This body was knocked down and robbed)

CONTRIBUTORY (SECONDARY) Compound Fracture of leg Bright's disease
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.
, 19____ (Address) _____

*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 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

194B

5-2076