

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

Do not use this space.

22091

1. PLACE OF DEATH

County Marion Registration District No. 527
Township Mason Primary Registration District No. 3929
City Hannibal (No. 118 Summit)

File No. _____
Registered No. 174
St. 6 Ward)

2. FULL NAME

Robert Norton Mahood
(a) Residence. No. 118 Summit St., 6 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) June 17-31
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
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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) Hannibal Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER Welch C. Mahood
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ralls County Mo.
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Mary Kaebell
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Pike County Mo.
(STATE OR COUNTRY)

14. INFORMANT Welch C. Mahood
(Address) Hannibal Mo.

15. FILED 6/20 1931 CC Cousins
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 18- 1931
17. I HEREBY CERTIFY, That I attended deceased from June 18, 1931, to June 19, 1931, that I last saw alive on June 17, 1931, and that death occurred, on the date stated above, at 6:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Hemorrhage
160B

(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY nutritional deficiency
(SECONDARY) (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED 160B
IF NOT A PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____
WHAT TEST CONFIRMED DIAGNOSIS 160B
(Signed) Rob Norton, M. D.
, 19 _____ (Address) Parsonal Ave

*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 Next Bowling Green Mo
Lawrence Cemetery DATE OF BURIAL 6-19- 1931

20. UNDERTAKER Schwartz Funeral Home ADDRESS 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.

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