

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

Do not use this space.

9237

1. PLACE OF DEATH

64 County Monroe Registration District No. 547
1 Township Monroe Primary Registration District No. 3099
8 City Hannibal (No. 314 North St)

File No. _____
Registered No. 76
St. 10 Ward

2. FULL NAME Catherine Budget Becker

(a) Residence, No. 314 North St 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. da. 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) Widow
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John A.
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 14th 1857
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 75 74 8 24 25
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Harpford 2
Virginia

13. NAME John Tobin

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

15. MAIDEN NAME Budget Begett

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

17. INFORMANT Miss William Jones
(ADDRESS) Hannibal Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Mary's Cem. DATE 12/13/1932

19. UNDERTAKER James O'Connell
(ADDRESS) Hannibal Mo.

20. FILED 3/15 1932 to E. Cloussin
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 9th 1932

22. I HEREBY CERTIFY, That I attended deceased from 3-7-1932 to 3-9-1932
I last saw her alive on 3-4-1932 Death is said to have occurred on the date stated above, at 10:45 pm.

The principal cause of death and related causes of importance were as follows:

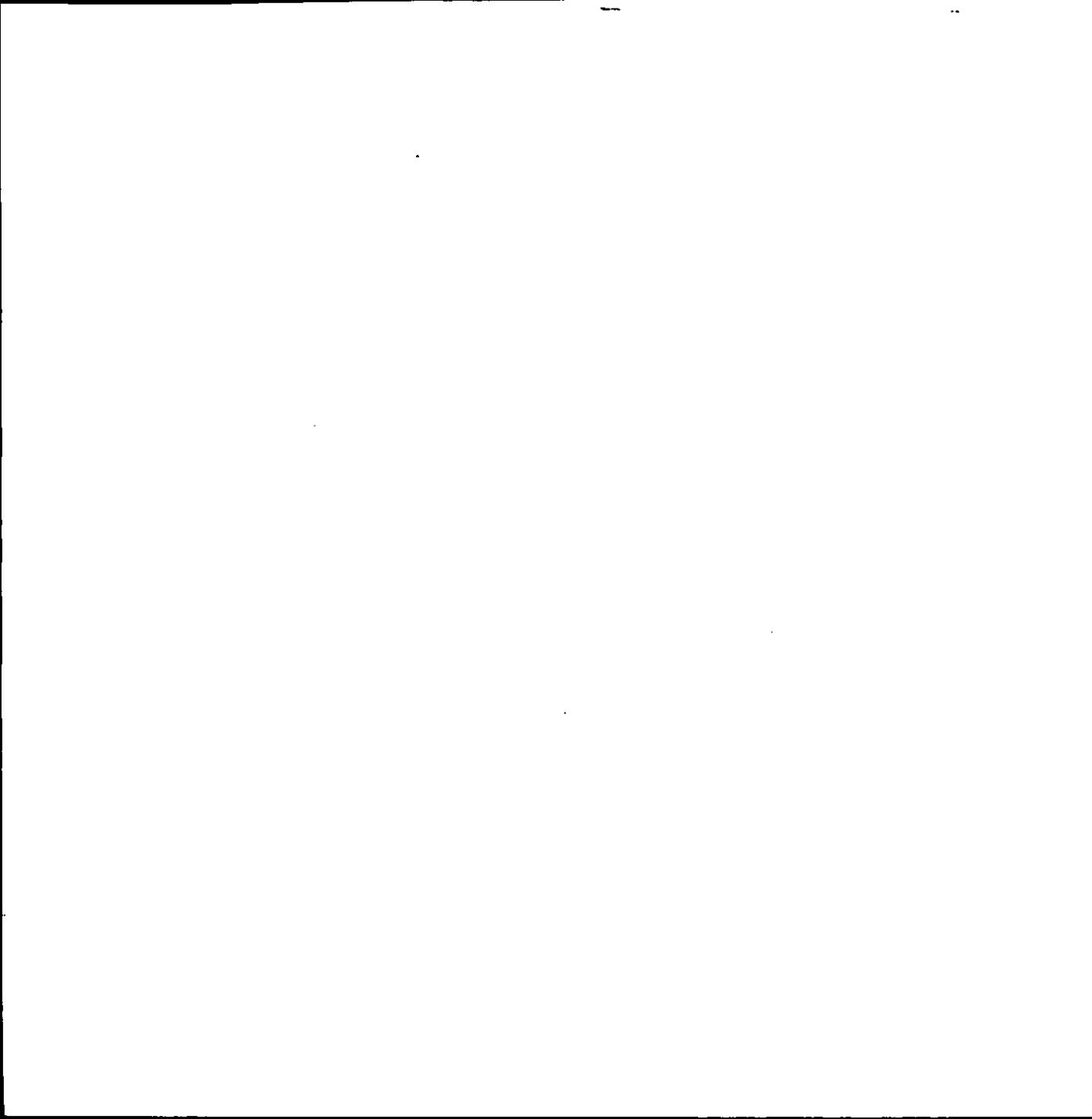
Paralysis
9:50
3:10
9:17
Other contributory causes of importance:
arterio sclerosis
heart disease
(myocarditis) (1)

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.
Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____
(Signed) W. P. Diney, M. D.
(Address) Hannibal Mo.



**MISSOURI STATE BOARD OF HEALTH
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ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Marion Registration District No. 347
Township _____ Primary Registration District No. 3129
City Hannibal (No. _____) St. _____ Ward _____

File No. _____
Registered No. 76

2. FULL NAME

Catherine Budget Becker

(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.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19

19. UNDERTAKER (ADDRESS)

20. FILED _____, 19 _____

Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 9 - 1932

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____

I last saw h _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Asphyxia
Hemiplegia
Date of onset _____
Other contributory causes of importance:
Asthenia, sclerosis of heart disease (myocarditis)

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) _____, M. D.

(Address) _____

SUPPLEMENTARY

5-92372