

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

Do not use this space.

1. PLACE OF DEATH

County Marion Registration District No. 547
 Township Mason Primary Registration District No. 3019
 City Hannibal (No. St. Elizabeth Hospital) St. Ward)

File No. 17413
 Registered No. 178

2. FULL NAME

Marcus R. Bourne

(a) Residence. No. Palmyra, Mo. 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. 2 mos. 1 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) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Almeta Ward Bourne

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 7, 1867

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>67</u>	<u>1</u>	<u>24</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Marion County
 (STATE OR COUNTRY) Missouri

10. NAME OF FATHER John J. Bourne

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

12. MAIDEN NAME OF MOTHER Fannie Dingle

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

14. INFORMANT Mrs. Fannie Bourne
 (Address) Palmyra, Mo.

15. FILED May 4, 1934 R. H. Sabin REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 1, 1924

17. I HEREBY CERTIFY, That I attended deceased from 2 24 1924 to 3-1 1924 that I last saw him alive on 3-1 1924 and that death occurred, on the date stated above, at 10.25 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Septicemia
137 (duration) yrs. 1 mos. 10 ds.
Prostatic obstruction
 (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? yes DATE OF 2-24-34

WAS THERE AN AUTOPSY? no 3-5-34

WHAT TEST CONFIRMED DIAGNOSIS? clinical

(Signed) R. H. Sabin 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 Palmyra, Mo. DATE OF BURIAL 5/3/24

20. UNDERTAKER Lewis Bros ADDRESS Palmyra, Mo.

JUN 23 1934

APR 29 1947

#2 *Marion*

DEPARTMENT OF COMMERCE

E. T. McLaugh, M. D.,

BUREAU OF THE CENSUS *17413*

Special Agent,
Jefferson City, Mo.

WASHINGTON

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Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: *Marcus R. Bourne*

Who died at _____ on *May - 1 - 19*

Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex *M* Color or race *W* Single, married, widowed or divorced: _____

Date of birth _____ Age: Years *67* Months *1* Days *24*

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month *12* Year *19*

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

Principal cause of death: *Septicemia - Resulting from obstruction from prostatic gland*

Other contributory causes of importance *Prostatic obstruction*

Name of operation *Prostatectomy* Date of _____

What test confirmed diagnosis? *Chemical* Was there an autopsy? *no*

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 _____

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

If so, specify _____

Name of physician _____

Address of physician _____

Signature of Registrar *[Signature]*

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. No. *547*

Primary Reg. Dist. No. *3029*

Very truly yours,

E. T. McLaugh. M.D.

Special Agent.

S-17413

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2007