

# MISSOURI STATE BOARD OF HEALTH

## BUREAU OF VITAL STATISTICS

### CERTIFICATE OF DEATH

19174

Do not use this space.

**JUN 15 1939**

**1. PLACE OF DEATH**

(a) County Marion Registration District No. 547  
 (b) Township Marion Primary Registration District No. 3039  
 (c) City Hannibal (d) Street No. Revering Hospital Registered No. 168  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

**2. PRINT FULL NAME**

(a) Residence, No. 635 Mable S. Breeding  
211 1/2 St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 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 Samuel

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 9, 1894

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ..... hrs. or ..... min.
	44	5	13	

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Tavern  
 9. Industry or business in which work was done, as saw mill, bank, etc. Owner  
 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) Chamberburg Ill

FATHER 13. NAME Lora Stephenson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New Orleans La

MOTHER 15. MAIDEN NAME H. Lillard

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

17. INFORMANT (ADDRESS) Miss Margaret Malone Hannibal Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Grandview DATE May 18, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) James O'Donnell Hannibal Mo

20. FILED May 20, 1939 H. E. Fisher Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 15, 1939

22. I HEREBY CERTIFY, That I attended deceased from May 14, 1939, to May 15, 1939  
 I last saw him alive on May 15, 1939 Death is said to have occurred on the date stated above, at 2:55 p.m.  
 The principal cause of death and related causes of importance were as follows:

Gunshot wound of head  
 Other contributory causes of importance: 167

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? Accidental injury May 15, 1939  
 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 Gunshot  
 Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? If so, specify .....  
 (Signed) J. Breeding M. D.

(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.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Michael J. Bloumel

Licensed Embalmer No. 3246

P. O. Address Hannibal, Mo

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**