

REC'D AUG 18 1939

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

26231
Do not use this space.

1. PLACE OF DEATH
 (a) County Marion Registration District No. 547
 (b) Township Marion Primary Registration District No. 3079
 (c) City Harrisburg (d) Street No. 1603 Broadway St.
 (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 Thelma F. Hixner
 (a) Residence, No. 1603 Broadway 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) Widow

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF John A.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July-31-1908

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
31 / 11 / 20

OCCUPATION
 8. Trade, profession, or particular kind of work done, as a lawyer, bookkeeper, etc. Housewife
 9. Industry or business in which work was done, as saw mill, bank, etc. Shoe Merchant
 10. Date deceased last worked at this occupation (month and year) 7/22/39 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marion City MO

FATHER
 13. NAME Chas. B. Bayram
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Shelby County MO

MOTHER
 15. MAIDEN NAME O. Vera Gaines
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Shelby County MO

17. INFORMANT Mr. Chas. B. Bayram
 (ADDRESS) Marion City, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE MT. Olive DATE July 25, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) James S. O'Donnell
Harrisburg, Mo.

20. FILED July 25, 1939 W. E. Fisher
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 22, 1939

22. I HEREBY CERTIFY, That I attended deceased from July 22, 1939, to July 22, 1939, 19...
 I last saw her alive on July 22, 1939, 19... Death is said to have occurred on the date stated above, at 6:30 p.m.
 The principal cause of death and related causes of importance were as follows:
Principale
By Hanging self.
 Date of onset 16/39

Other contributory causes of importance: 16/39

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

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? Sw. I. S. D. - Date of injury 7-22, 1939
 Where did injury occur? Harrisburg, Marion, Mo
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
Home

Manner of injury ---
 Nature of injury ---

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify ---
 (Signed) James O'Donnell Coroner
Harrisburg, Mo. M. D.
 (Address) Harrisburg Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. OCCUPATION should be stated EXACTLY. PHYSICIANS should state EXACTLY.

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. Conroy*

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.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

26231

Do not use this space.

1. PLACE OF DEATH

(a) County Marion Registration District No. 547
(b) Township Hannibal Primary Registration District No. 3029
(c) City Hannibal (d) Street No. _____ St. _____
(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.

Registered No. 218

2. PRINT FULL NAME

Thelma F. Hinner
(a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Wed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 7-31-1908

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
30 11 21

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as 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)

FATHER
13. NAME

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

MOTHER
15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE _____ DATE _____ 19____

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Sept 9 1939 Edm Lucke
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) _____, 19____

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

I last saw him 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:

Date of onset

Other contributory causes of importance:

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) _____

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

SUPPLEMENTARY

1939

5-26231