

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

Do not use this space.

FILED FEB 7 1940

1. PLACE OF DEATH

County *Mason*
Township *Mason*
City *Hannibal*

Registration District No. *547*

Primary Registration District No. *3079*

File No. *3047*

Registered No. *25* St. _____ Ward _____

2. FULL NAME

(a) Residence, No. *213 Hannibal* 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 *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) *Married*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *July 7 - 1899*

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hra. ormin.
41 6 4

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) *Pike County Ill.*

13. NAME *Ernest Waters*

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

15. MAIDEN NAME *Sarah Mae Stille*

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

17. INFORMANT (ADDRESS) *Mr. Harold Morgan Hannibal Mo.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Hannibal Cemetery* DATE *1/12/40*

19. UNDERTAKER (ADDRESS) *James C. Thompson Hannibal Mo.*

20. FILED *1-15-40* 19 *40* *W C Fisher* Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *1/11/40* 19 *40*

22. I HEREBY CERTIFY, That I attended deceased from *1-1-39* to *1-11-40* 19 *40*
I last saw her alive on *1-11-40* 19 *40* Death is said to have occurred on the date stated above, at *4:40 am.*

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

Ch. myocarditis
Ch. nephritis & edema
Other contributory causes of importance: *121*

Name of operation _____ Date of _____
What test confirmed diagnosis? *Ceb* 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) *J. R. Reardon*, M. D.
486 (Address) *1307 Broadway*

WHITE PRINTED, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

Harold O'Sullivan
3889
Hannibal Mo

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **3047**
Registrar's No. _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **547**

Primary Registration District No. **3029**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Marion

(b) City or town Hannibal
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Elsie May Heacock

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife Unknown 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased July 7 1899
(Month) (Day) (Year)

8. AGE: Years 41 Months 6 Days 4 If less than one day _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 6/19/1940 (b) E. M. Ruck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

19. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 1 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____ that last saw him alive on _____ 19 _____ and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature J. J. Ruckman, M.D. (Date of death) _____
Address Hannibal, Mo.

SUPPLEMENTARY

S-3047