LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

CAUSE OF DEATH is very important. Please give a full statement of OCCUPATION is very important.

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

1 PLACE OF DEATH

County: Marion

Township: ~~Hunson~~ or

Village or City: Hannibal (NO. Market, St.; 5 Ward)

Registration District No.: 547 File No.: 14581

Primary Registration District No.: 3029 Registered No.: 425

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Margaret Partlow

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: June 4, 1841 (Month) (Day) (Year)

7 AGE: 77 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry business, or establishment in which employed (or employer):

9 BIRTHPLACE (City or town, State or foreign country): Germany.

PARENTS

10 NAME OF FATHER: Henry Nilson

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Germany.

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Germany.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry Partlow
(Address) Hannibal Mo

15 Filed 4/28, 1919 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

2

16 DATE OF DEATH: April 23, 1919 (Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from April 1, 1919, to April 23, 1919, that I last saw her alive on April 21, 1919, and that death occurred, on the date stated above, at 6:15 P. m.

The CAUSE OF DEATH* was as follows:

107A Broncho Pneumonia
162 Senility

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) R. C. Schmidt M. D.
4-27, 1919 (Address) Hannibal, Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Fairview DATE OF BURIAL: April 24, 1919

20 UNDERTAKER: Wm. M. Smith ADDRESS: Hannibal

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ..... St. ..... Ward)

[If death occurred in hospital or institution give its NAME instead of street and number.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... 1.....
(Month) (Day) (Year)

7 AGE

.....yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or .....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ..... 191.... ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

....., 191....
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191...., to ....., 191.... that I last saw him alive on ....., 191.... and that death occurred, on the date stated above, at .....

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) .....yrs. .....mos.

CONTRIBUTORY .....
(Secondary)

..... (Duration) .....yrs. .....mos.

(Signed) ..... M.D.

....., 191.... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL | **DATE OF BURIAL** ....., 191..

20 UNDERTAKER | **ADDRESS**