

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

Do not use this space.

15811

**1. PLACE OF DEATH**

County Mason  
Township Mason  
City Hannibal

Registration District No. 547  
Primary Registration District No. 3027  
No. 512 Lindell Ave

File No. ....  
Registered No. 167  
St. 5 Ward)

**2. FULL NAME**

Giba Andrew Bird  
(a) Residence. No. 512 Lindell Ave, St. 5 Ward.

(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred 18 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 17 - 1863

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.  
64 | 4 | 13 | — | — | —

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Street Car Work  
(b) General nature of industry, business, or establishment in which employed (or employer) Running Cars.  
(c) Name of employer Hannibal Railway Co.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Palmit Ohio

PARENTS

10. NAME OF FATHER George Bird

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

12. MAIDEN NAME OF MOTHER Mary Brown Buggs

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

14. INFORMANT (Address) Raymond Bird  
Burlington Iowa

15. FILED 6/2, 1927 C. A. Strode  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 30 - 1927

17. I HEREBY CERTIFY That I attended deceased from Jan 17, 1927, to May 30, 1927. That I last saw h. alive on May 30, 1927 and that death occurred, on the date stated above, at 10:15 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
General Arterial Sclerosis

CONTRIBUTORY (SECONDARY) Coronary (duration) 5 yrs. mos. da.

WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH.....  
DID AN OPERATION PRECEDE DEATH?..... DATE OF.....  
WAS THERE AN AUTOPSY?.....  
WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) A. R. Roscoe, M. D.  
6-2, 1927 (Address) 228 Broadway, Hannibal

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MANNER AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mt. Olivet Cemetery DATE OF BURIAL June 1 - 1927

20. UNDERTAKER Schwartz Funeral Home Hannibal ADDRESS

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.

ONE 8 1927



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Marion Registration District No. 5+7 File No. \_\_\_\_\_  
 Township Hamibal Primary Registration District No. 3029 Registered No. 167  
 City \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

John Andrew Bird  
 (a) Residence. No. \_\_\_\_\_ 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Wd

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) \_\_\_\_\_

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

**8. OCCUPATION OF DECEASED**

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

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY) \_\_\_\_\_

10. NAME OF FATHER \_\_\_\_\_

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

12. MAIDEN NAME OF MOTHER \_\_\_\_\_

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

14.

INFORMANT \_\_\_\_\_  
 (Address) \_\_\_\_\_

15.

FILED 6/2 27 CE Shode REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 30 19 27

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

General arteriosclerosis  
Paralysis  
 (duration) 5 yrs. mos. ds.  
 CONTRIBUTORY (SECONDARY) Properly (duration) \_\_\_\_\_ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_

IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.

, 19\_\_\_\_ (Address) \_\_\_\_\_

\*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 \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

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

SUPPLEMENTARY

S-15741