

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

Do not use this space.

1. PLACE OF DEATH

County Marion
Township Massena
City Hannibal

Registration District No. 547
Primary Registration District No. 2029

File No. X
Registered No. 5639
St. _____ Ward _____

2. FULL NAME

Effie Shea
(a) Residence No. 610 Walnut St., _____
(Usual place of abode)

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 13-1878

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>50</u>	<u>11</u>	<u>8</u>		

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) Mo

10. NAME OF FATHER Seagraves Utterback

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

12. MAIDEN NAME OF MOTHER Walter Soules

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

14. INFORMANT S. B. Utterback (Address) Hannibal, Mo

15. FILED Feb 20 1928 C. E. Strode REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-19 1928

17. I HEREBY CERTIFY That I attended deceased from 7:18, 1928, to 3-19, 1928 that I last saw h. alive on 2-19, 1928, and that death occurred, on the date stated above, at 11:27 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral hemorrhage
740 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Typhoid (duration) 7 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH: Hannibal Mo

DID AN OPERATION PRECEDE DEATH: no DATE OF _____

WAS THERE AN AUTOPSY: no

WHAT TEST CONFIRMED DIAGNOSIS: _____ (Signed) J. J. Tanner, M. D.

719, 1928 (Address) Hannibal Mo

*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 De Masses Chapel DATE OF BURIAL 2-20 1928

20. UNDERTAKER James O'Donnell 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.

MAR 20 1928

DEPARTMENT RECORD

