

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

Do not use this space
+ 2445

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.

1. PLACE OF DEATH

County Missouri Registration District No. 547
 Township Payson Primary Registration District No. 3039
 City Hannibal No. 1004 S. Green St. 5 Ward

File No. _____
 Registered No. 3
 _____ St. 5 Ward

2. FULL NAME

(a) Residence. No. 1004 S. Green 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 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 W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) _____

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 18-1928

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
7 9 1 26 = _____ 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) Hannibal Mo
 (STATE OR COUNTRY)

10. NAME OF FATHER Frank Green

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

12. MAIDEN NAME OF MOTHER Leanna St. James

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

14. INFORMANT Terrika Green
 (Address) 1004 S. Green St

15. FILED 1/5-29 1929 E. Storde REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-24-1929
 17. _____

I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at about 9:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Suffocation, Cause
Transmitted by Bed
Clothing
1892 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) 180
 (duration) yrs. mos. da.

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

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____ 34

WHAT TEST CONFIRMED DIAGNOSIS?
Cosumer James O. Daniel
 (Signed) (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 Robinson DATE OF BURIAL 1/6 1929

20. UNDERTAKER Geo E Roberts ADDRESS Hann

