

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

Do not use this space.

2466

1. PLACE OF DEATH

County Marion
Township Mason
City Hannibal (No. 2412 Market)

Registration District No. 547
Primary Registration District No. 3979

File No. _____
Registered No. 26
St. _____ Ward _____

2. FULL NAME

Marion Ates

(a) Residence. No. 2412 Market St. 6 Ward.

Length of residence in city or town where death occurred 4 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

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

Rachel Frances Ates

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

April 12-1841

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<u>87</u>	<u>9</u>	<u>17</u>	

8. OCCUPATION OF DECEASED

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

9. BIRTHPLACE (CITY OR TOWN)

Payson Ill
(STATE OR COUNTRY)

10. NAME OF FATHER

John Ates

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Balvuth Co. Penn.
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Abigail Cleveland

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Balvuth Co. Penn.
(STATE OR COUNTRY)

14. INFORMANT

Rachel Frances Ates
(Address) Hannibal Mo

15. FILED

1/30 1929 C. E. Shode REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Jan. 29-1929

17.

I HEREBY CERTIFY That I attended deceased from Jan. 15 1929 to Jan. 29 1929 that I last saw h. 1 AM alive on Jan. 29 1929, and that death occurred, on the date stated above, at 2:30 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Arterio-sclerosis

CONTRIBUTORY Functional Heart disease (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) E. R. Motley, M. D.

, 19 (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

DATE OF BURIAL

Payson Ill

1/31-1929

20. UNDERTAKER

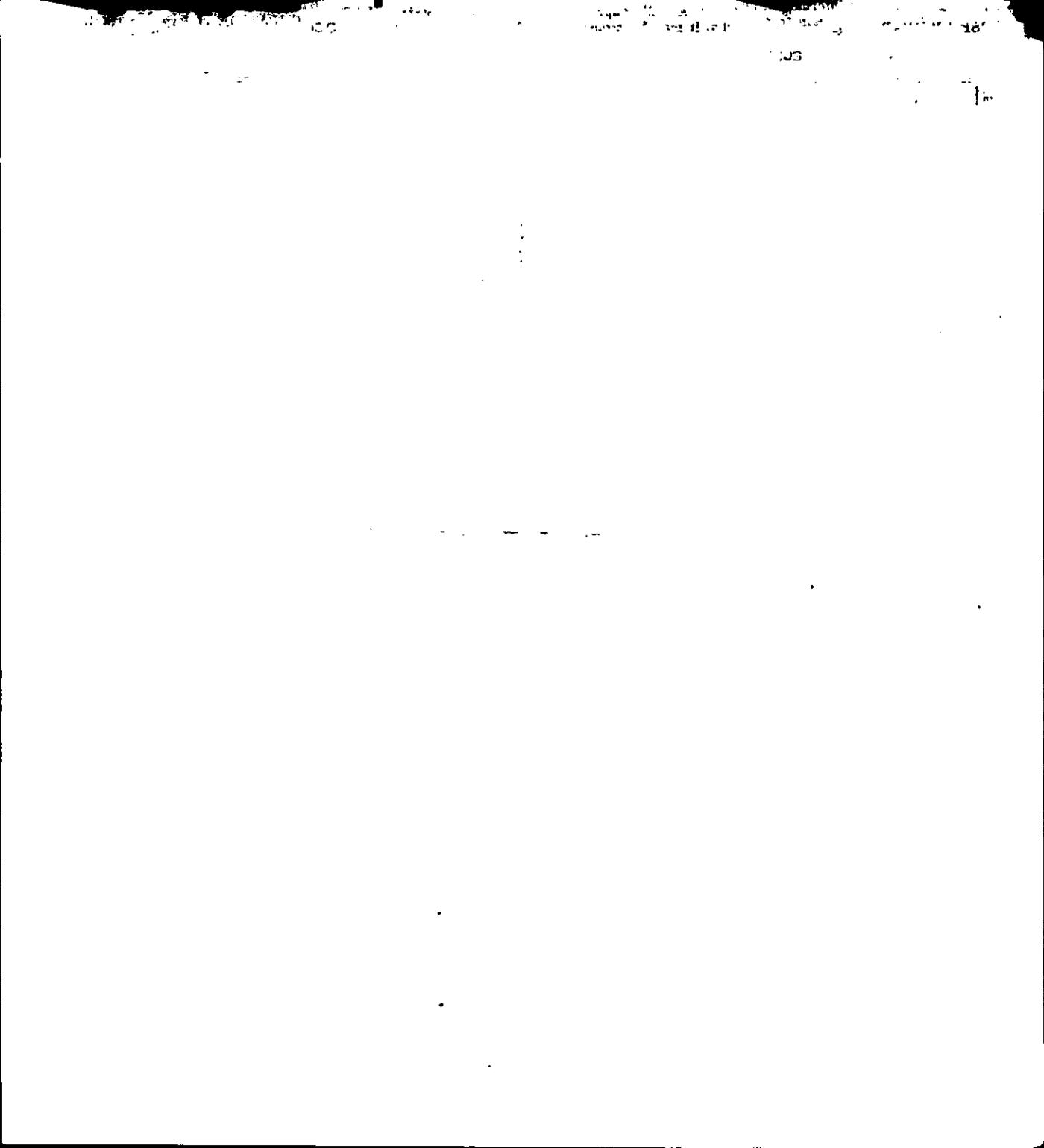
ADDRESS

Schwartz Funeral Home Hannibal Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION if very important.

9 1929
64
8

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2
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2



**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. 547

File No. _____

Township _____

Primary Registration District No. 3029

Registered No. 26

City Hannibal (No. _____)

St. _____ Ward _____

2. FULL NAME

Marion Allen

(a) Residence. No. 2712 Market 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

M.

4. COLOR OR RACE

W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

M.

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 1/30, 1929 66 Street REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 24 1929

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:

Atherosclerosis

CONTRIBUTORY (SECONDARY) Functional Heart Disease
there was a very marked dis-
turbance in action of heart for one year.

18. 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) E. R. Moley, M. D.

, 19____ (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 **DATE OF BURIAL**

19

20. UNDERTAKER **ADDRESS**

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain language, 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-2466