

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

Do not use this space.

X 15344

**1. PLACE OF DEATH**

County Marion Registration District No. 547 File No. \_\_\_\_\_  
 Township Marion Primary Registration District No. Waverly Registered No. 95  
 City Hammill 908 S Arch 2019 St. 5th Ward)

**2. FULL NAME**

(a) Residence. No. 908 S Arch St., 5th Ward. (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 Female 4. COLOR OR RACE Wool 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) divorced

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 9-3-1869

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
60 7 5 \_\_\_\_\_

**8. OCCUPATION OF DECEASED**

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

9. BIRTHPLACE (CITY OR TOWN) Shelby County  
 (STATE OR COUNTRY) Missouri

10. NAME OF FATHER Wm Wilson

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

12. MAIDEN NAME OF MOTHER Harnett Sanders

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

14. INFORMANT Mrs E. M. Lewis  
 (Address) 908 S Arch

15. FILED 4/11/29 C. E. Stool REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-8 1929

17. I HEREBY CERTIFY That I attended deceased from March 7 1929 to April 8 1929 and that I last saw him alive on April 8 1929 and that death occurred, on the date stated above, at 8:05 A. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Cerebral apoplexy  
arterio sclerosis  
 (duration) 1 yrs. 1 mos. 0 da.  
 (SECONDARY) (duration) \_\_\_\_\_

**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? \_\_\_\_\_

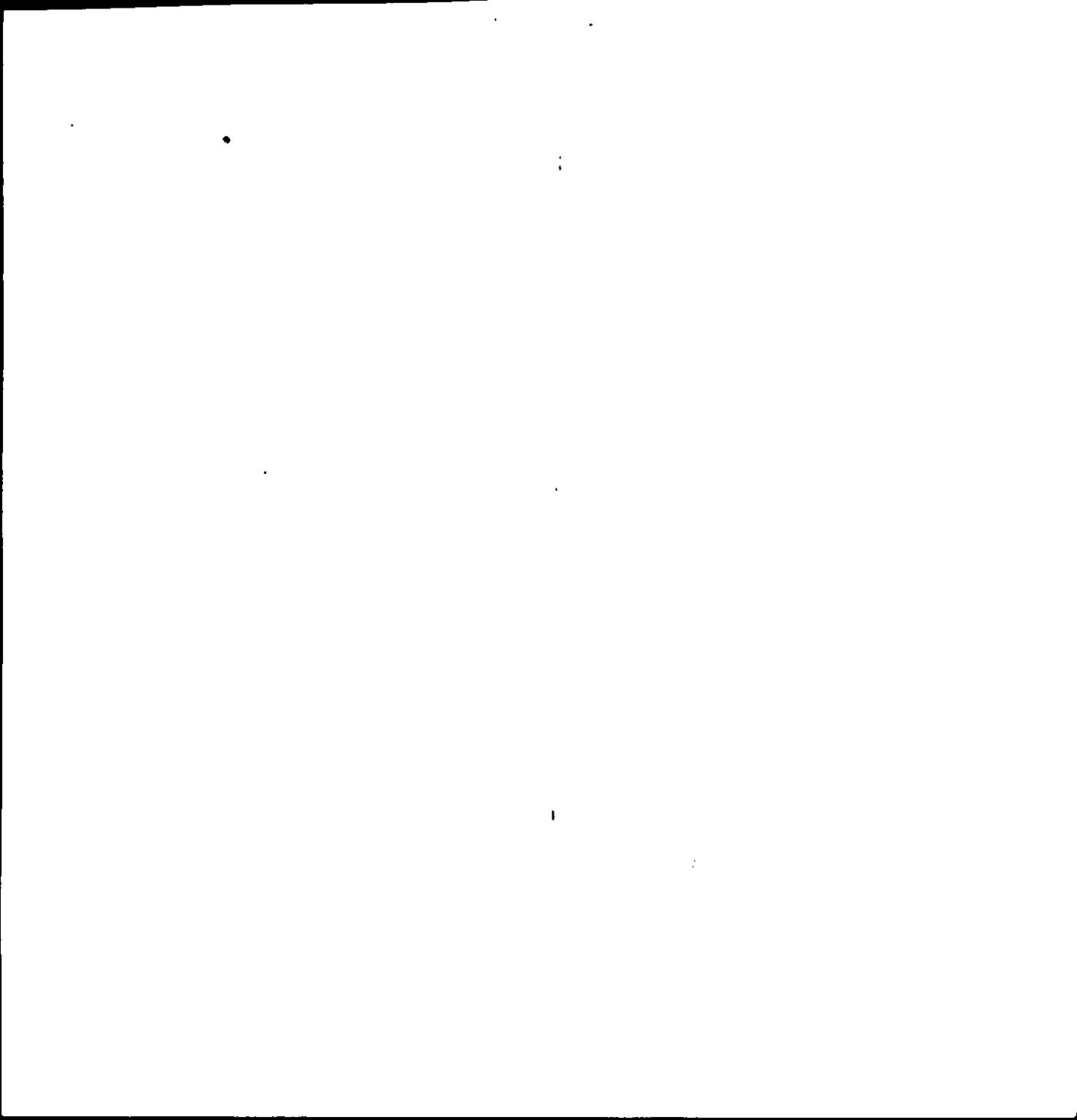
(Signed) A. W. Fox, M. D.

4-12, 1929 (Address) Hammill, 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 Cem DATE OF BURIAL 4/11 1929

20. UNDERTAKER Geo E Roberts ADDRESS Hammill



**MISSOURI STATE BOARD OF HEALTH  
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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. 98-  
 City Garnett (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Anna Belle Buckner

(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 F 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED OR DIVORCED decd (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 3-1869

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>59</u>	<u>7</u>	<u>3</u>	<u>5</u>	

**8. OCCUPATION OF DECEASED**

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

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY)

**PARENTS**

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 4/12/19 66 Stude REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/8 1929

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 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:

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) yrs. mos. ds.

**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) \_\_\_\_\_, 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 \_\_\_\_\_

**SUPPLEMENTARY**

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES OF DEATH

S-15344