

JUN 27 1929

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

Do not use this space.

Dr. Bigney
18787

1. PLACE OF DEATH

County Marion Registration District No. 547
Township Mason Primary Registration District No. 3029
City Hannibal (No. 1207) Church

File No. _____
Registered No. 139
St. _____ Ward _____

2. FULL NAME

Elizabeth Jane Tillitt
(a) Residence. No. 1207 Church 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 MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 28 1929

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF James H. Tillitt

17. I HEREBY CERTIFY, That I attended deceased from May 28, 1929, to May 28, 1929, that I last saw her alive on _____, 19____, and that death occurred, on the date stated above, at 5:45 p. m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 8 1846

THE CAUSE OF DEATH* WAS AS FOLLOWS:
chronic myocarditis & nephritis
131
930

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
83 7 20

(duration) 1621 yrs. mos. ds.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

CONTRIBUTOR (SECONDARY) Senility
(duration) _____ yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Canada

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

10. NAME OF FATHER Daniel Shaver

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

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

20. WAS THERE AN AUTOPSY? no

12. MAIDEN NAME OF MOTHER unknown

WHAT TEST CONFIRMED DIAGNOSIS (Signed) W. B. Bigney M. D.

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

6-1-1929 (Address) Hannibal Mo

14. INFORMANT Mrs. H. P. Tabot (Address) Hannibal Mo

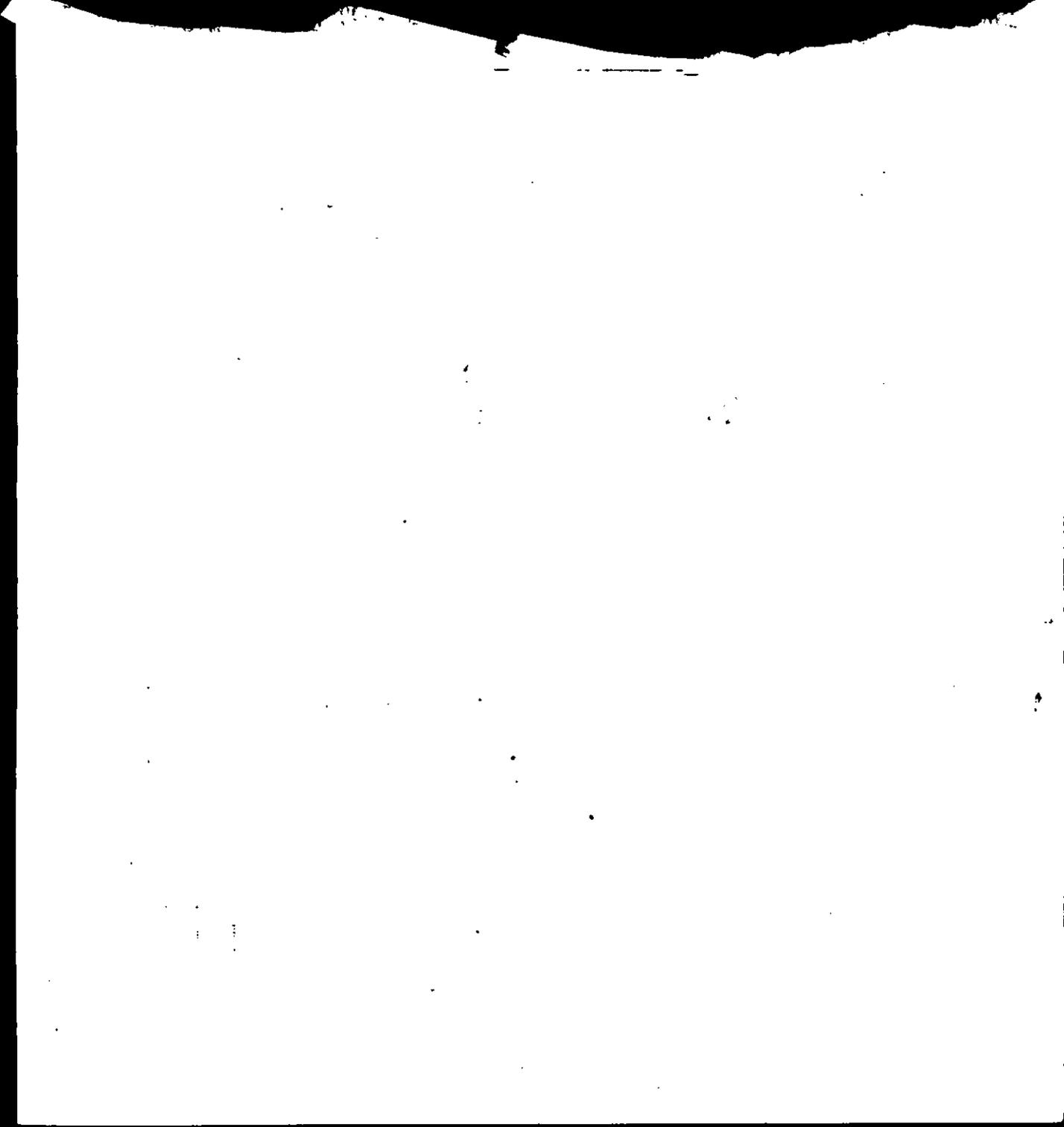
*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

15. FILED 6/1 19 29 C. E. Strade REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mt. Olivet DATE OF BURIAL May 30 19 29

20. UNDERTAKER Mrs. M. Smith ADDRESS Hannibal

CAUSE OF DEATH
STATE OF MISSOURI
DEPARTMENT OF HEALTH



**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. 3089 Registered No. 139
 City Hannibal (No. _____) St. _____ (Ward)

2. FULL NAME

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 8-1846

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
82 7 20

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)

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 9/1 1929 G.E. Strode REGISTRAR
me

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 28 1929

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

_____ (duration) _____ yrs. mos. ds.
 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 _____

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated accurately. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly certified.

REGISTRARS SHALL STATE NAMES OF DECEASED. THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-18787