

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

Do not use this space.

3777-1

1. PLACE OF DEATH

County Marion Registration District No. 547 File No. _____
 Township Mason Primary Registration District No. 3029 Registered No. _____
 City Hannibal (No. St. Elizabeth Hospital St. _____ Ward)

2. FULL NAME

(a) Residence. No. 806 Smith St. 5 Ward. (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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. ~~H~~ MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Louette Carter

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan 4-1858

7. AGE YEARS* MONTHS DAYS IF LESS than 1 day, hrs. or min.
71 10 2

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) 178
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Ralls Co Mo
 (STATE OR COUNTRY)

10. NAME OF FATHER Rowland Little

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 R. D. Carter
 (Address) Hannibal Mo

15. FILED Nov 7 1929 C. C. Causey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 6 1929

17. I HEREBY CERTIFY, That I attended deceased from June 1928 to Nov 6 1929
 that I last saw him alive on Nov 6 1929 and that death occurred, on the date stated above, at 9 A. M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

myocarditis
Gas anesthetic (duration) yrs. mos. ds.
 CONTRIBUTORY Gall Stones (SECONDARY) swell
myocarditis (duration) yrs. mos. ds.

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

1. DID AN OPERATION PRECEDE DEATH? yes DATE OF Nov 6 41
 WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS General autopsy
 (Signed) A. L. Shanks 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 Barkley New London DATE OF BURIAL Nov. 8 1929

20. UNDERTAKER Wm Smith ADDRESS Hannibal

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

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.

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PARENTS

