

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

Do not use this space.

22669

1. PLACE OF DEATH

County Hannibal
Township Bearton
City (No.)

Registration District No. 378
Primary Registration District No. 5-5-28

File No.
Registered No. 89
St. Ward

2. FULL NAME

Thos B Magruder
(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 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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 31-1884

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>76</u>	<u>3</u>	<u>18</u>	<u>18</u>	<u> </u>

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired Carpenter
(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 Daniel Magruder

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

12. MAIDEN NAME OF MOTHER Emanda George

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

14. INFORMANT Frank S. Sisson
(Address) Highway B. R. 1

15. FILED 7/30 1930 V. C. Burham
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 11 1930

17. I HEREBY CERTIFY, That I attended deceased from , 1930, that I last saw him alive on April 11 1930, and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Paralysis
820
97

CONTRIBUTORY (SECONDARY) arteriosclerosis
(duration) yrs. mos. ds.

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

0 DID AN OPERATION PRECEDE DEATH? DATE OF NO

WAS THERE AN AUTOPSY? NO

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) G. H. F. M. M. D.
7/13 1930 (Address) Highway B. R. 1

*State the DISEASE CAUSING DEATH, or to 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 Hannibal Mo DATE OF BURIAL July 13 1930

20. UNDERTAKER ADDRESS
C. L. Ireland Highway

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 and EMPLOYMENT.

State
of

MENT OF
EXACTLY

W. R. -- Row

**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 Howard Registration District No. 278 File No. _____
 Township Benton Primary Registration District No. 3328 Registered No. 39
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Thos B McSunder
 (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

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED M
 (write the word)

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) _____

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 11 19 30

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Paralysis
Hemiplegia
Arterio-sclerosis
 CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED _____ (duration) yrs. mos. ds.
 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.

14. INFORMANT _____ (Address) _____

15. FILED 7/30, 1930 V. C. Bonham REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____ 19 _____

20. UNDERTAKER _____ ADDRESS _____

K. 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-22669