

SEP 25 1930

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

Do not use this space.

27284

1. PLACE OF DEATH

County Marion Registration District No. 547 File No. \_\_\_\_\_  
Township Marion Primary Registration District No. 3429 Registered No. 176  
City Hannibal (No. St. Elizabeth Hospital St. \_\_\_\_\_ Ward) \_\_\_\_\_

2. FULL NAME Ella May Glass

(a) Residence. No. 921 Church St. St. 3 Ward. \_\_\_\_\_ (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 12 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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 24-1886

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
44 2 10

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 " "

9. BIRTHPLACE (CITY OR TOWN) Brookfield Mo.  
(STATE OR COUNTRY)

10. NAME OF FATHER Corn Sheehan

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

12. MAIDEN NAME OF MOTHER Mary Sheehan

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

14. INFORMANT James E. Glass  
(Address) Hannibal Mo.

15. FILED Aug 4 1930 C. E. Considine REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 4 1930

17. I HEREBY CERTIFY, That I attended deceased from 7-24, 1930 to 8-4, 1930 and that I last saw him alive on 8-4, 1930 and that death occurred, on the date stated above, at 7:30:00 a. m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Peritonitis  
1513  
38  
15-7 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 2 ds.  
CONTRIBUTORY (SECONDARY) Malaria - appendicitis  
(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

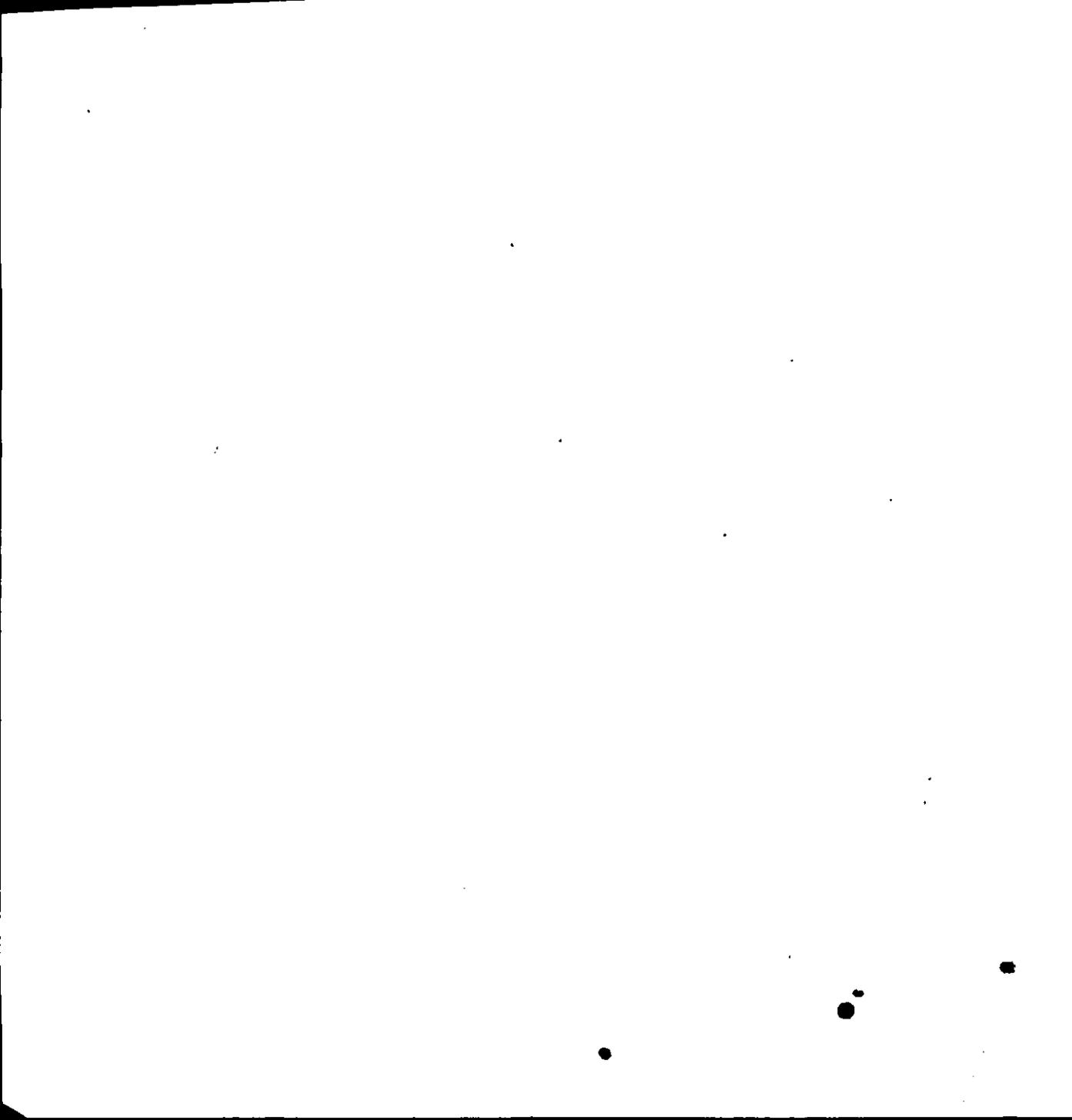
18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, Place of death  
DID AN OPERATION PRECEDE DEATH? Yes DATE OF 7-24-30  
WAS THERE AN AUTO. SYM? No  
WHAT TEST CONFIRMED DIAGNOSIS? Clinical  
(Signed) Dr. Herdner, 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 Brookfield Mo. DATE OF BURIAL 19

20. UNDERTAKER Schwartz Funeral Home ADDRESS Hannibal Mo.



**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. 196

City Hannibal (No. ....) St. .... Ward)

**2. FULL NAME**

Ella May Glass

(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) 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 8/4 1930 W. Colours REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 4 19 30

17. I HEREBY CERTIFY That I attended deceased from ..... 19....., 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:

Peritonitis

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

Unknown 19

20. UNDERTAKER

ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS RESCR. 161. 100

SUPPLEMENTARY

S-27284