

NOV 26 1930

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

Do not use this space.

33534

1. PLACE OF DEATH

County Marion Registration District No. 247
Township Mason Primary Registration District No. 3079
City Hannibal (No. 614 South Main St. 4 Ward)

2. FULL NAME

Marion Jean Webb
(a) Residence. No. 614 South Main St. 4 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 2 - 1930

7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ofmin.
15

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) Hannibal Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER Marion J. Webb

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

12. MAIDEN NAME OF MOTHER Menora Martin

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

14. INFORMANT Marion J. Webb
(Address) Hannibal Mo.

15. FILED Oct. 17 30 E. Clausen
REGISTRAR

1 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct. 17 - 1930

17. I HEREBY CERTIFY, That I attended deceased from Oct. 9, 1930, to Oct. 9, 1930, that I last saw him alive on Oct 9, 1930 and that death occurred, on the date stated above, at 5:30 P.M.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Aspiration
accidental
10 1/2 (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) Mr. H. Hays, M. D.

10/17 1930 (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 DATE OF BURIAL

Mt. Olivet Cemetery Oct. 18 - 1930

20. UNDERTAKER ADDRESS

Schwartz Funeral Home Hannibal Mo

N. B.—Every effort should be made to ascertain the exact cause of death, and to place it in its proper perspective. AGE should be stated EXACTLY. PHYSICIAN'S should state exactly classified. Exact statement of OCCUPATION is very important.

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

2. FULL NAME

Marion Jean Webb
 (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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S
(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) _____

14. INFORMANT _____
 (Address) _____

15. FILED Oct 17 1930 W.C. Conner
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 17 1930

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 _____.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Respiration age related; Mother had baby in her lap + rolled it on it in her sleep -
 (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) W. H. Hays, M. D.
 _____, 19____ (Address) Hannibal 910

*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 _____ 19____

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

N. B. - Information should be carefully supplied. In case of state PHYSICIAN'S or state CAUSE OF DEATH, it may be properly classified. Exact statement of OCCUPATION of DECEASED. REGISTRARS SHALL NOT REGISTER UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

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