

MAR 2 1933

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

Do not use this space.

1. PLACE OF DEATH

County Marion Registration District No. 547
Township Marion Primary Registration District No. 2029
City Hannibal (No. M. Elizabeth Hospital St. 6 Ward) File No. 40620
Registered No. 2

2. FULL NAME

(a) Residence, No. 917 Pleasant St. 6 Ward. (If nonresident, give city or town and State)
(Usual place of abode)

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) Feb. 12th 1920

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
12 10 4

OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Student
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. 1780
10. Date deceased last worked at this occupation (month and year) 10 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Louisiana no

FATHER 13. NAME Henry Paschal

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill

MOTHER 15. MAIDEN NAME Anna Mae Anderson

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) no

17. INFORMANT Henry Paschal
(ADDRESS) 917 Pleasant St. Hannibal, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE mt Olivet DATE 12/18/32, 19

19. UNDERTAKER James O. Daniel
(ADDRESS) Hannibal, Mo.

20. FILED Dec 29 1932 Blausewe
Registrar.

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12/16/32, 19

22. I HEREBY CERTIFY, That I attended deceased from
....., 19....., to....., 19.....

I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at 2:30 P.M.

The principal cause of death and related causes of importance were as follows:
Date of onset

Bilateral Lobar
Pneumonia

Other contributory causes of importance:

Toxic myocarditis
apendicitomy

Name of operation Appendectomy Date of Feb 10-32

What test confirmed diagnosis chart and Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury....., 19.....

Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
Nature of injury..... (1)

24. Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) John R. Rechner, M. D.

(Address) 1501 Cedar

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.

...eally supp... e
...he prop...
...PHYSICIANS ap...
...ATION is 761...

**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

Township Hannibal

Primary Registration District No. 3029

City Hannibal (No.)

File No.

Registered No. 2

St. Ward

2. FULL NAME

Chas. Hayden Paschal

(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 (write the word)

S

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. ormin.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 16, 1932

22. I HEREBY CERTIFY, That I attended deceased from

....., to, 19.....

I last saw h..... alive on, 19..... Death is said

to have occurred on the date stated above, at.....m.

The principal cause of death and related causes of importance were as follows:

Bilateral lobar pneumonia

Date of onset

12/1

Other contributory causes of importance:

Toxic myocarditis
appendectomy

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed)....., M. D.

(Address).....

FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

Age should be supplied. AGE should be stated EXACTLY. PHYSICIANS should state properly classified. Exact statement of OCCUPATION is very important.

For what purpose was the appendectomy performed? Appendicitis? Cancer?

MENTAL COPY

5-4062-0