

SEP 19 1938

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

29687  
Do not use this space.

1. PLACE OF DEATH

(a) County Marion Registration District No. 547  
 (b) Township Marion Primary Registration District No. 3079  
 (c) City Hannibal (d) Street No. 1321 Wardlaw St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred 7 mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

William S. Prentiss  
 (a) Residence, No. 1321 Wardlaw St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWER OR DIVORCED Widower

5A. IF MARRIED, WIDOWER OR DIVORCED HUSBAND OF (OR) WIFE OF Late Mollie

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 2, 1862

7. AGE YEARS 77 MONTHS 10 DAYS 17  
 If LESS than 1 day, ..... hrs. or ..... min.

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

FATHER  
 13. NAME Winters

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

MOTHER  
 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS) Julia Redden  
1321 Wardlaw

18. BURIAL, CREMATION, OR REMOVAL PLACE Southside, Kentucky DATE 8/22 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. H. Daniel  
Hannibal, Mo.

20. FILLED BY W. H. Daniel 1938 W. H. Daniel Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-19- 1938

22. I HEREBY CERTIFY, That I attended deceased from 6-29 1939, to 8-18 1939  
 I last saw him alive on 8-18 1939. Death is said to have occurred on the date stated above, at 7:35 Am.

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

Cerebral Hemorrhage  
Arterio Sclerosis  
 Date of onset

Other contributory causes of importance:  
Arterio Sclerosis

Name of operation..... Date of.....  
 What test confirmed diagnosis?..... Was there an autopsy? no

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? no  
 If so, specify.....  
 (Signed) W. H. Daniel, M. D.  
 (Address) 227a, Broadway

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.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed

*M. J. [Signature]*

Licensed Embalmer No. 3246

P. O. Address Hannibal

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to con  
with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

29687

Do not use this space.

1. PLACE OF DEATH

(a) County Marion Registration District No. 547  
(b) Township ..... Primary Registration District No. 3029 Registered No. ....  
(c) City Hannibal (d) Street No. .... St. ....  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 695 William S. Prentiss St.  (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-19, 1939

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

22. I HEREBY CERTIFY, That I attended deceased from

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct-2-1862

19     to     , 19    

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.  
76 ~~77~~ 10 17

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:

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

Date of onset

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Other contributory causes of importance:

13. NAME

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

Name of operation ..... Date of

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

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

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.

17. INFORMANT (ADDRESS)

Manner of injury .....

Nature of injury .....

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

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

(Signed) H. G. Daniel, M. D.  
(Address) Hannibal

20. FILED 10 19 39 Em. Jude Local Registrar

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

SUPPLEMENTARY

